

Patient Intake Form

Please answer **all** questions and sign **every** page.

Name _____ My Pronouns Are _____ Date _____
Last Name First Name Middle

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Female Male Non-Binary Decline to answer Other _____
Status Married Single Partnered Other Minor (under 18) No. of Children _____

PHONE NUMBERS / CONTACT (check preferred contact)

Home _____ Business _____ Cell _____
E-mail address _____ Check if you *do not* want us to contact you via e-mail
Person Responsible for this account _____

** INSURANCE ** PLEASE COMPLETE **

Please indicate your Primary Insurance _____
Primary Subscriber's Name _____ Subscriber's Birth Date ____/____/____
MEMBER ID / POLICY # _____ **Group #** _____ **Co-Payment \$** _____

EMPLOYMENT INFORMATION / EMERGENCY CONTACT

Occupation _____ Full Time Part Time F/T Student Retired
In case of Emergency, Contact Name _____ Phone _____ Relationship _____

What is the reason for your visit? _____

How did your symptoms begin? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

How often do you experience your symptoms?
 Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Please describe the nature of your symptoms? Sharp Dull Ache Numb Shooting Burning Tingling Other _____

Current Problem is the result of a: *Check all the apply* Work accident Car Accident Other, specify _____

****PLEASE SIGN****
Patient Signature _____ Date _____

Does the pain spread to other areas? No Yes (if so, where?) _____

How much has your pain interfered with your normal work (including outside the home and housework) ?

Not at all A little bit Moderately Quite a bit Extremely

Is this condition interfering with your Work Sleep Other, specify _____

What activities aggravate your condition? _____

What makes it feel better? _____

Any Other Complaints? _____

OTHER DOCTORS SEEN FOR THIS CONDITION Medical Doctor Physical Therapist Chiropractor No one Other _____

Doctor's Name _____ Diagnosis _____

Other Doctor(s) Name _____

Did you have X-rays MRI CT Urinalysis Blood tests Other, specify _____

Physical Therapy, duration? _____ Medication, list _____

What were the results of your care? _____

EXERCISE

None Light Moderate Heavy Consists of _____

HABITS

Smoking (packs/day) _____ Do not smoke Quit smoking _____ yrs ago Alcohol (drinks/week) _____ Caffeine (drinks/week) _____

PLEASE LIST ALL PRESCRIBED MEDICATIONS , OVER-THE-COUNTER MEDICATIONS, HERBS, VITAMINS AND INHALERS:

NAME OF MEDICATION / WHY PRESCRIBED	DOSAGE	FREQUENCY USED
_____	_____	_____
_____	_____	_____
_____	_____	_____

****PLEASE SIGN****

Patient Signature _____ Date _____

REVIEW OF SYSTEMS: Please help us identify your potential health risks, check any that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Condition (Heart Attack, Valve Disease / Blockage) | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain (Angina) | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney / Bladder Stones |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Vascular Condition / Stroke | <input type="checkbox"/> Kidney / Bladder Infection |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Lung Condition / Emphysema / COPD | <input type="checkbox"/> Loss of Bladder Control |
| <input type="checkbox"/> Elbow / Upper Arm Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Wrist / Hand Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Hip / Upper Leg Pain | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Knee / Lower Leg Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Ankle / Foot Pain | <input type="checkbox"/> Liver / Gallbladder Disorder | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Heartburn / Indigestion / GERD | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Joint Swelling / Stiffness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Spinal Disc Pathology | <input type="checkbox"/> Loose Stools | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Loss of Bowel Control | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Abnormal Weight Gain |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Allergies to: _____ |

PLEASE LIST ANY PRIOR MAJOR ILLNESSES OR CONDITIONS

PLEASE LIST PRIOR INJURIES / SURGERIES / HOSPITALIZATIONS:

REASON	YEAR	HOSPITAL	OUTCOME

PLEASE INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING CONDITIONS. WHICH FAMILY MEMBER?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Condition (Heart Attack, Valve Disease / Blockage) _____ | <input type="checkbox"/> Cancer _____ | |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Other Serious health condition not listed _____ | |

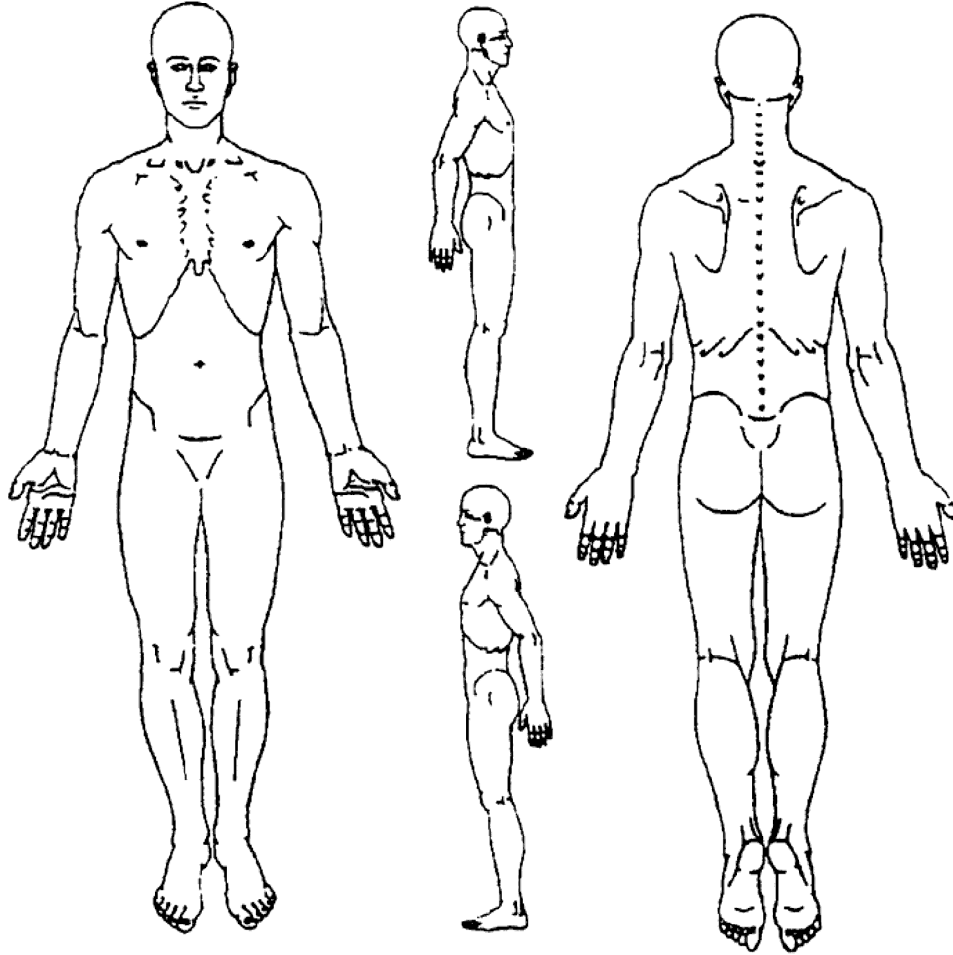
Is there anything else you would like the doctor to know about you, your condition, or your general health status? (Please describe) _____

Who referred you to this office? _____ May we thank them? []yes []no

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Mark areas of radiation. Include all affected areas.

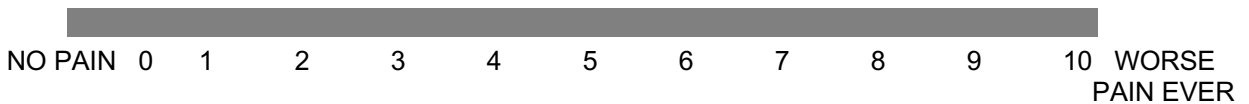
Use appropriate symbols:

Numbness ---- Pins & Needles oooo Burning xxxx
Aching **** Stabbing ////

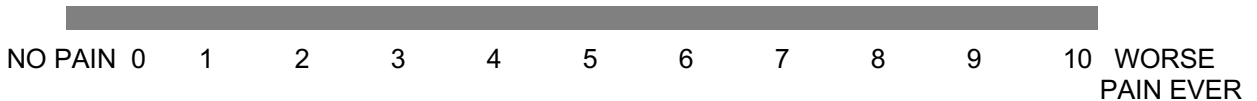


VISUAL ANALOG PAIN SEVERITY SCALE

Please place a mark on the line that corresponds to your *current* pain.



Please place a mark on the line that corresponds to your *average* pain.



PLEASE SIGN

Patient Signature _____ Date _____