Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your response are important to help us better understand the health issues you face and ensure the *delivery* of the best possible treatment.

Emergency Contact:._____

Phone number:_ _ _ _ _ _ _ _ _ _ _ _

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ . □ male □ female

Address: _____

_____ Marital status

SSN#: _____ IslMlwlol.sePI

Phone#: home: _____ work: _____

E-mail address: _____

Occupation:----'---Employer: _____

Check@ and indicate the age when you had any of the following:

General
- D Allergies
- D Depression
- D Dlzi:lness
- D Fainting
- D Fatigue
- D Fever
- D Headaches
- D Loss of sleep
- ☐ Mental illness ,
- D Nervousness •
- ☐ Tremors
- D Weight loss/ gain

Muscle / Joint
- ☐ Arthritis/ rheumatism
- D Bursitis
- D Foot trouble
- D Muscle weakness
- O Low back pain
- D Neck pain
- D Mid back pajn
- D Joint pain

Skin
- D Boils
- D Bruise easily
- D Dryness
- O Hives or allergies
- D Itching
- ☐ Rash
- D Varicose veins

Eye, Ear, Nose S. Throat
- D Colds
- 0 Dearness
- D Earache
- D Eyepaln
- D Gumtrouble
- D Hoarseness.
- 0 Nasal obslructio
- D Nose bleeds
- D Ringing of the·ears
- D Sinus Infection
- D Sore throat
- D Tonslllltis
- O Vision problems

Gastrointestinal
- D Abdominal pain
- D Bloody or tarry stool .
- D Colitis/ Crohn's
- D Colon trouble
- D Constipation
- D Diarrhea
- D Difficult digestion
- D Oiverticulosis
- D Bloated abdomen
- D Excessive hunger
- 0 Ganbladder trouble
- D Hernia
- 0 Hemorrhoids
- D Intestinal worms
- D Jaundice
- D Liver trouble
- D Nausea
- D Painful deification
- D Pain overstomach
- D Poor appetite
- D Vomiting
- D Vomiting of blood

Genitourinary
- D Bed-wet Ung
- D Bladder Infection
- D Blood in urine
- ☐ Kidney Infection
- D Kidney stones
- D Prostate trouble
- D Pus in urine
- ☐ Stress Incontinence

Urination
- 0 Overnight more than twice
- D More than 8x In 24hrs
- D Decreased flow fforce
- ☐ Painful urination
- D Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- D Pain over heart
- D Palpitation
- D Poor circulation
- D Rapid heartbeat
- D Slow heartbeat
- D Swelllng of ankles

Respiratory
- D Chestpaln
- D Chronic cough
- D Difficulty breathing
- D Hayfever
- D Shortness of breath
- D Spitting up phlegm/blood
- D Wheezing

Women1inly
- ☐ Congested breasts
- D Hot flashes
- D Lumps In breast
- D Menopause
- ☐ Vaginal discharge

Menstrual flow
- ☐ Reg. ☐ Irreg. ☐ Pain/ cramps

Days of flow:_ lenglh of cycle: _

Date - 1n day last period:

Ara you pregnant? D yes, D no

If yes, how many months? _

How many children do you have? _

Birth control method: _____

Date of last PAP test _____

☐ normal, D abnormal

Date of last mammogram:

D normal, D abnormal

Check any of the conditions **you· have or have h.ad:**
- D Alcoholism
- D Anemia
- D Appendicitis
- D Arteriosclerosis
- D Asthma
- D Bronchitis
- D Cancer
- D Chicken pox
- D Coldsores
- D Diabetes
- D Eczema
- D Edema
- D Emphysema
- D Epilepsy
- ☐ Goiter
- D Gout
- D Heartburn
- D Heart disease
- D Hepatitis
- D Herpes
- D High cholesterol
- D HIV/AIDS
- D Influenza
- 0 Malaria
- D Measles
- D Miscarriage
- D Multlple sclerosis
- D Mumps
- D Numbnes$/tlnglln g
- D pacemaker
- D .Osteoporosis
- D Pneumonia
- D Polio
- ☐ Rheumatic fever
- 0 Slroke
- 0 Thyroid disease
- O Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief d tailed description of the problem yqu are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is It getting worse? o yes, □ no _____

Does it bother you (check appropriate box): o work, o sleep, □ other: _____

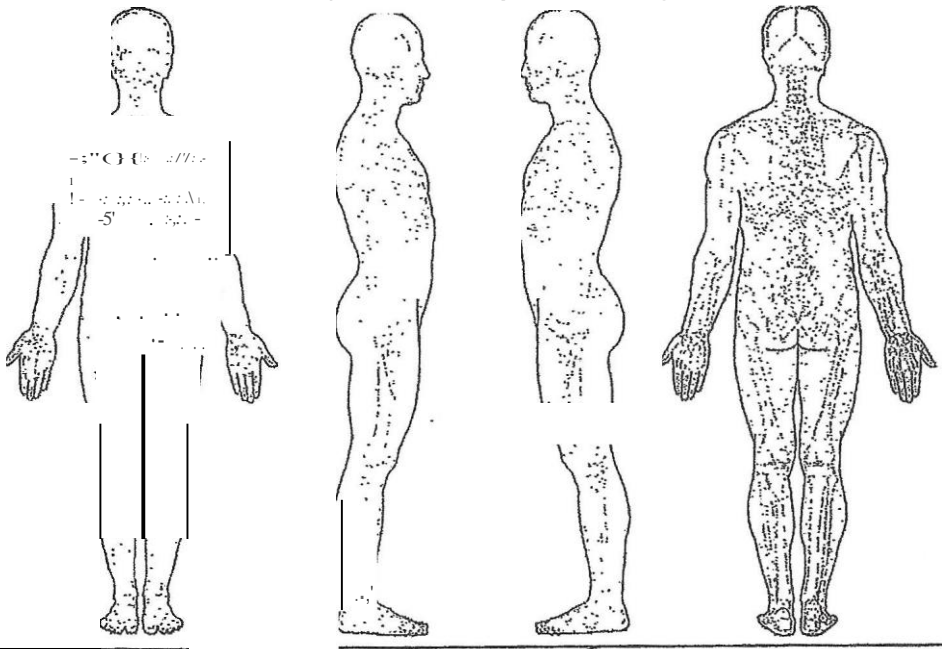
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst.
·P-ossible
·Pain

- N.P .
· Rain . ·



Past health history

Have you...	Yes	No	If yes, explain briefly
...been hospitalized in the last 5 year?	o	o	_____
... had any mental disorders?	□	□	_____
...had any broken bones?	o	o	_____
..:had any strains or sprains?	o	o	_____
...ever used orthotics?	o	o	_____
Do you take minerals, herbs or vitamins?	o	o	_____

How is most of your day spent? o standing, o sitting, o other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	0	D	D	D
Coffee	D	D	D	D
Tobacco	D	D	0	D
Drugs	D	D	D	D
Exercise	D	D	D	D
Sleep	0	0	D	□
Soft drinks	D	D	0	D
Salty foods	□	0	□	□
Water	0	D	D	□
Sugar	D	D	D	D

Family hi ry

If any blood relative has had any of the following conditions, please check and indicate which r.elative{s)

- □ Alcoholism
- □ Anemia
- o Arterio clerqsi
- o Arthritis
- □ Asthma
- o Bleed easily
- o Cancer
- o Diabetes
- Emphysema
- o Epilepsy
- o Glaucoma
- o Heart disease
- o High blood pressure
- o High cholesterol
- o Multipl _ cleros_i . __.
- o Osteoporosis
- o Stroke
- □ Thyroid·disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

Patient Signature: _____ Date: _____