Patient Intake Form

Name: _____ **Date:** _____

Date of Birth: _____ ☐ **Male** ☐ **Female** ☐ **Other**

Address: _____

_____ **Marital Status:**

SSN#: _____ **S M W D SEP**

Insurance: _____

Phone #: Cell: _____ **Other:** _____

E-Mail: _____

Occupation/Employer: _____

Note: Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand your health issues you face and ensure the delivery of the best possible treatment.

Emergency Contact:

_____

Phone number: _____

Check boxes and indicated the age when you had any of the following:

General:

- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Mental Illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss/gain

Muscle / Joint:

- ☐ Arthritis/Rheumatism
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Muscle Weakness
- ☐ Low back Pain
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Joint pain

Skin:

- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or Allergies
- ☐ Itching
- ☐ Rash

Eye, Ear, Nose, & Throat:

- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum Trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems
- ☐ Sinus infection

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Bloody or Tarry Stool
- ☐ Colitis/Crohn's
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Diverticulosis
- ☐ Bloated Abdomen
- ☐ Excessive Hunger
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal Worms
- ☐ Jaundice
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Pain over stomach
- ☐ Poor Appetite
- ☐ Vomiting

Women Only:

- ☐ Congested breast
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual Flow:

Days of flow: _____

Length of cycle: _____

Date: 1st day of last period: _____

would you say flow is:

☐ Reg. ☐ Irreg.

Are you pregnant? _____

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____ ☐ Normal ☐ Abnormal

Date of last mammogram: _____ ☐ Normal ☐ Abnormal

Cardiovascular:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pules
- ☐ Pain over heat
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory:

- ☐ Chest Pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay Fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Genitourinary:

- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate troubles
- ☐ Pus in urine
- ☐ Stress incontinence
- ☐ Painful urination

Check any of the conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Patient Intake Form

Please list any medications/supplements you are currently taking and why: _____

_____

_____

What is the purpose of your visit today? _____

What is your primary complaint? _____

Any other complaints? _____

What caused the current condition? _____ **When did it start?** _____

Does the pain radiate? If so, where?

_____

(Please circle your answers below)

Since your condition started, how has it changed? Getting Better Not Changing Getting Worse

How often do you experience this complaint? Constantly (100%) Frequently (75%) Occasionally (50%) Intermittently (<50%)

Does your complaint worsen? If so, when: Morning Midday Night Work Sleep Other _____

How much has the complaint interfered with your normal day to day life? (Work, outside the home, and housework)

Not at all A little bit Moderately Quite a bit Extremely

How much would you say this complaint has affected your social activities?

All the time Most of the time Half of the time Some of the time Not at all

Severity:

Use this key below to rate the severity of your pain. Please write in your number: _____

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe 7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating

Quality: How would you describe the current sensation of your complaint?

☐ Sharp pain ☐ Shooting pain ☐ Numbness ☐ Tingling ☐ Dull Ache ☐ Burning ☐ Throbbing

☐ Other _____

Previous Treatment:

Who have you seen for this condition?

☐ Medical Doctor ☐ Physical Therapist

☐ Chiropractor ☐ Other _____

Have you had Chiropractic/Physical Therapy care in the past?

☐ Yes ☐ No If so, When? _____

Family History:

If any blood relatives has had any of the following conditions,
Please check and indicate which relative(s)

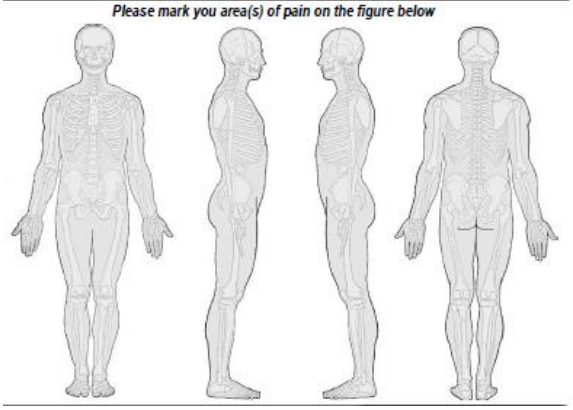
☐ Alcoholism	☐ Cancer	☐ High Blood Pressure
☐ Anemia	☐ Diabetes	☐ High Cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple Sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed easily	☐ Heart Disease	☐ Thyroid disease

Please note any additional information we may need to know in regards to your family history:

_____

_____

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



Habits:	None	Light	Mod.	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugars	☐	☐	☐	☐

Any additional habits that are not listed above:

Patient Signature: _____ Date: _____ Reviewed by Doctor: _____