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Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help me better understand the health issues your face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

Date of Birth: _____/_____/_____ **Gender:** _____ **Preferred Pronouns:** _____

Address: _____

_____

_____

Phone Number (cell preferred): _____

Email Address: _____

Occupation: _____

Emergency Contact: (name and number): _____

How did you hear about me: _____

Please check the box if applicable and indicate 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
□ 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
□ Varicose veins

Other:
_____
_____
_____
_____
_____

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
□ Painful defecation
□ Pain over stomach
□ Poor appetite
□ Vomiting
□ Vomiting of blood

Genitourinary
□ Bed-wetting
□ Bladder infection
□ Blood in urine
□ Kidney infection
□ Kidney stones
□ Prostrate trouble
□ Pus in urine
□ Stress incontinence

Urination:
□ Overnight more than twice
□ More than 8x in 24 hours
□ Decreased flow/force
□ Painful urination
□ Urgency to urinate

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Hardening of the arteries
□ Irregular pulse
□ Pain over heart
□ Palpitation
□ Poor circulation
□ Rapid heartbeat
□ Slow heartbeat
□ Swelling of ankles

Respiratory
□ Chest pain
□ Chronic cough
□ Difficulty breathing
□ Hay fever
□ Shortness of breath
□ Spitting up phlegm/blood
□ Wheezing

Eye, Ear, Nose, & Throat
□ Colds
□ Deafness
□ Earache
□ Eye pain
□ Gum trouble
□ Hoarseness
□ Nasal obstruction
□ Nose bleeds
□ Ringing of the ears
□ Sinus infection
□ Sore throat
□ Tonsillitis
□ Vision problems

Miscellaneous conditions:
□ 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
□ Multiple Sclerosis
□ Mumps
□ Numbness/tingling
□ Pacemaker
□ Osteoporosis
□ Pneumonia
□ Polio
□ Rheumatic fever
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Ulcers

Provide a brief description of the problem you are currently experiencing: _____

_____

_____

_____

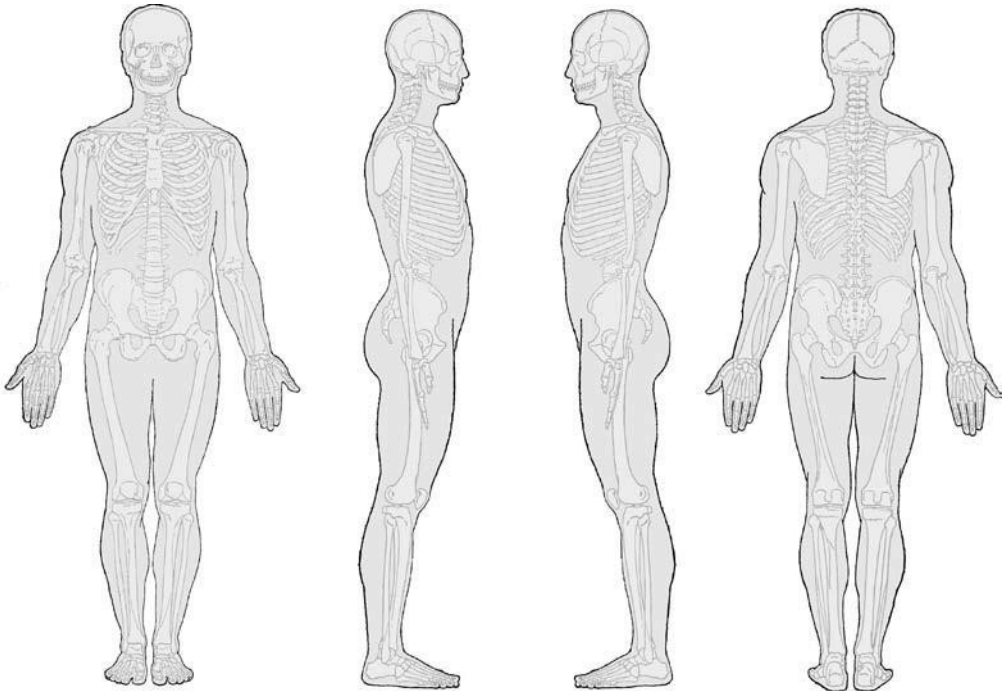
_____

How long have you had this condition? _____ Is it getting worse? □ Yes □ No _____

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

What seemed to be the initial cause? _____

Please mark your area(s) of pain on the figure below: (<u>shade it in</u>)



On a scale of 0 to 10, where 0 is no pain at all and 10 is the worst possible pain, please rank your pain below:

_____

Have you …	Yes	No	If yes, explain briefly
-been hospitalized in the last 5 yrs	□	□	_____
-had any mental health challenges	□	□	_____
-had any broken bones	□	□	_____
-had any strains or sprains	□	□	_____
-ever used orthotics	□	□	_____
Do you take minerals, herbs or vitamins	□	□	_____

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

How old is your mattress? _____

When was your last physical exam? _____

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

Please list any medication you are currently taken and why: _____

_____

_____

_____

Do you have any other health issues or concerns that I should be made aware of:

_____

_____

_____

Have you been to any other doctors for the problem you are currently experiencing? □ Yes □ No If yes, where have you been and what kind of treatment have you received?

Place and Type of Treatment	Date

Do you have x-rays, MRIs, or other diagnostic tests that have been done for this condition? □ Yes □ No If yes, what kind and where were they done?

Place and Type of Testing	Date

Do you feel that you are under a lot of stress (do you feel hurried, rushed, under pressure, or overwhelmed)?
□ Yes □ No If yes, please describe:

_____

_____

Have you experienced any significant life changes (moves, new jobs, losses, etc.) in the past year? □ Yes □ No
If yes, please describe:

_____

_____

How would you rate your current level of health? □ Excellent □ Good □ Fair □ Poor

On a scale of 0 to 10 (where 0 is no joy and 10 is being ecstatic), rate your average level of joy. _____
Please explain why you give yourself this rating:

_____

_____

Do you have any prior experience with chiropractic, massage, acupuncture, energy healing, or any other alternative therapies? □ Yes □ No If yes, please describe:

_____

_____