

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: _____

SSN#: _____ Marital status
lslMlwloI.sePl

Phone#: home: _____ work: _____

E-mail address: _____

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

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

<p>General</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Mental illness</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Weight loss/ gain</p> <p>Muscle / Joint</p> <p><input type="checkbox"/> Arthritis/ rheumatism</p> <p><input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Mid back pain</p> <p><input type="checkbox"/> Joint pain</p> <p>Skin</p> <p><input type="checkbox"/> Boils</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> Hives or allergies</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Varicose veins</p> <p>Eye, Ear, Nose S. Throat</p> <p><input type="checkbox"/> Colds</p> <p><input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Eyepain</p> <p><input type="checkbox"/> Gum trouble</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Ringing of the ears</p> <p><input type="checkbox"/> Sinus Infection</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Tonsillitis</p> <p><input type="checkbox"/> Vision problems</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Bloody or tarry stool</p> <p><input type="checkbox"/> Colitis/ Crohn's</p> <p><input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> Overticulosis</p> <p><input type="checkbox"/> Bloating abdomen</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Gallbladder trouble</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Intestinal worms</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Painful defecation</p> <p><input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting of blood</p> <p>Genitourinary</p> <p><input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> Bladder Infection</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Kidney Infection</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> Pus in urine</p> <p><input type="checkbox"/> Stress Incontinence</p> <p>Urination</p> <p><input type="checkbox"/> Overnight more than twice</p> <p><input type="checkbox"/> More than 8x in 24hrs</p> <p><input type="checkbox"/> Decreased flow/force</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Urgency to urinate</p>	<p>Cardiovascular</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Hardening of the arteries</p> <p><input type="checkbox"/> Irregular pulse</p> <p><input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> Palpitation</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> Slow heartbeat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p>Respiratory</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Spitting up phlegm/blood</p> <p><input type="checkbox"/> Wheezing</p> <p>Women only</p> <p><input type="checkbox"/> Congested breasts</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Vaginal discharge</p> <p>Menstrual flow</p> <p><input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/cramps</p> <p>Days of flow: _ length of cycle: _</p> <p>Date - 1n day last period: _____</p> <p>Are you pregnant? <input type="checkbox"/> yes, <input type="checkbox"/> no</p> <p>If yes, how many months? _</p> <p>How many children do you have? _</p> <p>Birth control method: _____</p> <p>Date of last PAP test _____</p> <p><input type="checkbox"/> normal, <input type="checkbox"/> abnormal</p> <p>Date of last mammogram: _____</p> <p><input type="checkbox"/> normal, <input type="checkbox"/> abnormal</p>	<p>Check any of the conditions you have or have had:</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> Colds/sores</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Ulcers</p>
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Please list any medication you are currently taking and why:

Patient Intake Form (side 2)

Give a brief detailed 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: _____

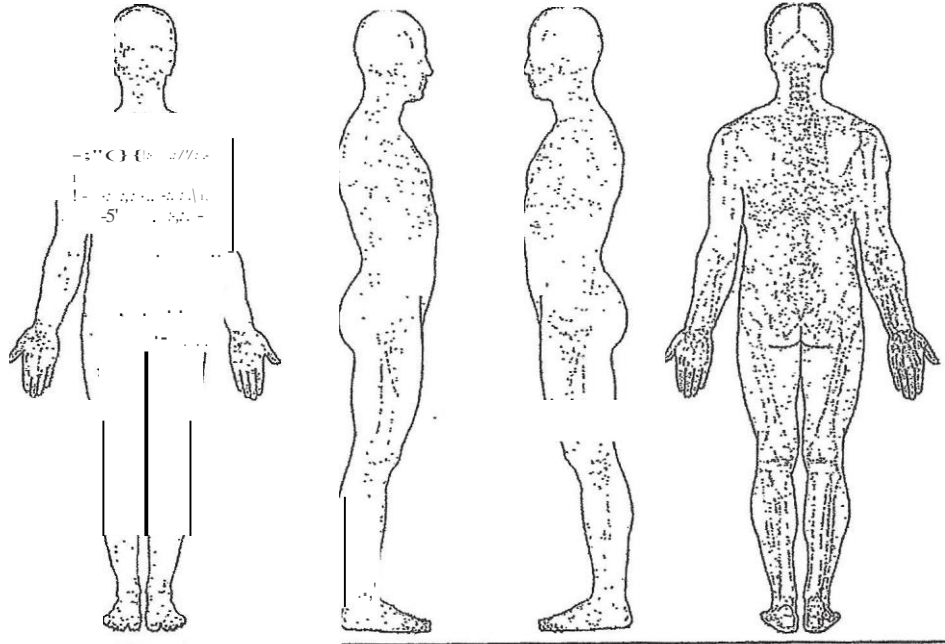
What seemed to be the initial cause: _____

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

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

Worst.
Possible
Pain

- NP
- Rain



Past health history

Have you... Yes No If yes, explain briefly

...been hospitalized in the last 5 year? _____

... had any mental disorders? _____

... 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arterioclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

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

Patient Signature: _____ Date: _____