Confidential Patient Intake Information

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information

Patient Name ______________________

Today's Date ____________ Date of Birth ____________

Social Security # ______________________

Address ______________________

City ______________________

State ______________ Zip __________

Gender: ❒ Male ❒ Female Height _______ Weight _______

❒ Single ❒ Married ❒ Partnered ❒ Engaged
❒ Separated ❒ Divorced ❒ Widowed ❒ Minor

How many children do you have? ______________

Please list any family members being treated here ____________

____

Occupation ______________________

Employer/School ______________________

Employer/School Address ______________________

____

Employer/School phone #: (_____) ______________

Contact Information

Home Phone (______) ______________________

Cell Phone (______) ______________________

Email address ______________________

May we contact you via (please check for all applicable):

❒ Home phone ❒ Cell ❒ Work phone ❒ Email

In case of emergency please contact:

Name ______________________

Relationship ______________________

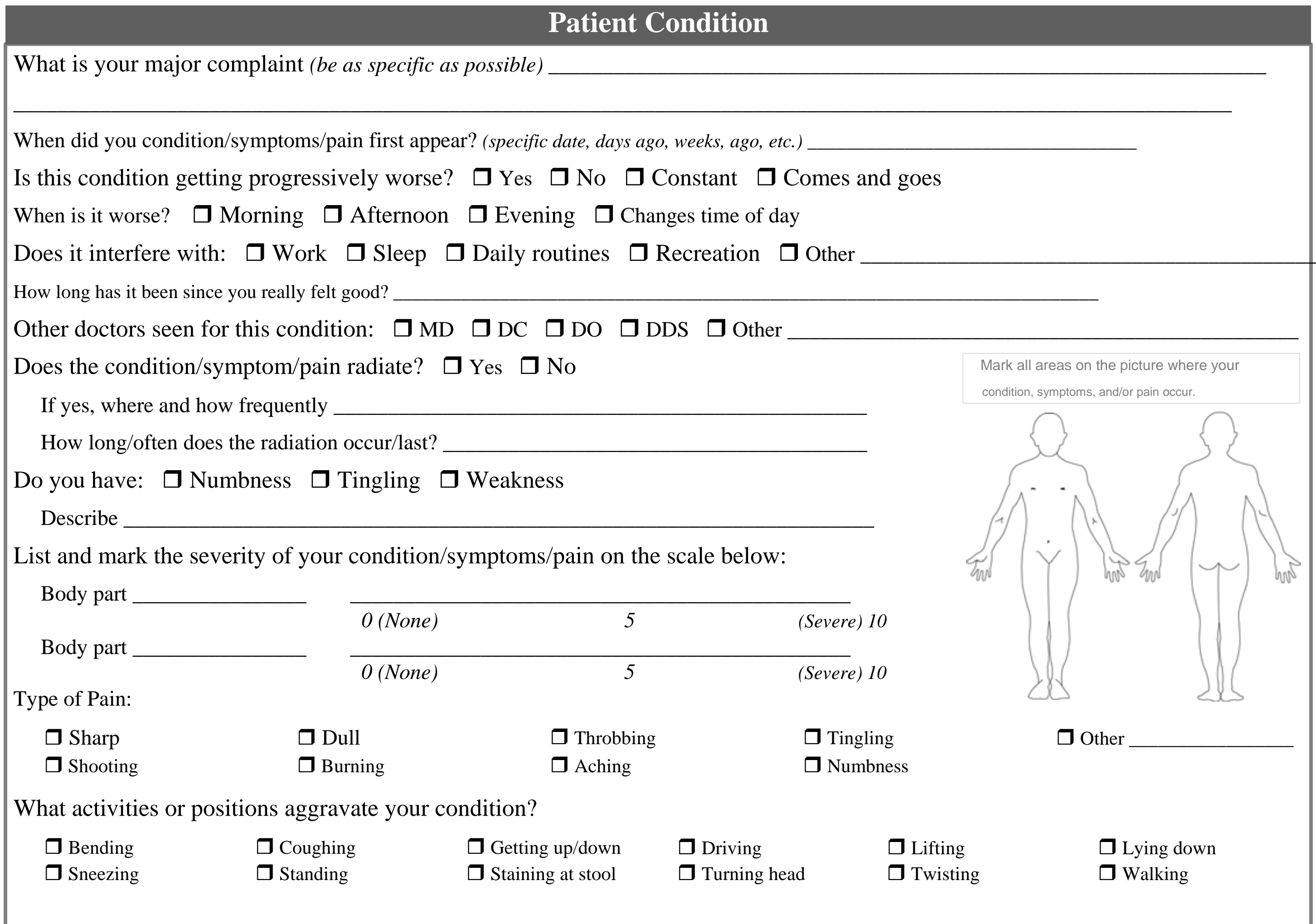
Home Phone (______) ______________________

Alternate Phone (______) ______________________

Spouse's/Partner's name ______________________

Spouse's/Partner's employer ______________________

Who referred you? ______________________



Patient Condition

What is your major complaint *(be as specific as possible)* ______________________

____

When did you condition/symptoms/pain first appear? *(specific date, days ago, weeks, ago, etc.)* ______________

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Constant ❒ Comes and goes

When is it worse? ❒ Morning ❒ Afternoon ❒ Evening ❒ Changes time of day

Does it interfere with: ❒ Work ❒ Sleep ❒ Daily routines ❒ Recreation ❒ Other ______________

How long has it been since you really felt good? ______________________

Other doctors seen for this condition: ❒ MD ❒ DC ❒ DO ❒ DDS ❒ Other ______________

Does the condition/symptom/pain radiate? ❒ Yes ❒ No

If yes, where and how frequently ______________________

How long/often does the radiation occur/last? ______________________

Do you have: ❒ Numbness ❒ Tingling ❒ Weakness

Describe ______________________

Mark all areas on the picture where your condition, symptoms, and/or pain occur.

List and mark the severity of your condition/symptoms/pain on the scale below:

Body part ______________ ______________________
0 (None) 5 *(Severe) 10*

Body part ______________ ______________________
0 (None) 5 *(Severe) 10*

Type of Pain:

❒ Sharp ❒ Dull ❒ Throbbing ❒ Tingling ❒ Other ______________
❒ Shooting ❒ Burning ❒ Aching ❒ Numbness

What activities or positions aggravate your condition?

❒ Bending ❒ Coughing ❒ Getting up/down ❒ Driving ❒ Lifting ❒ Lying down
❒ Sneezing ❒ Standing ❒ Staining at stool ❒ Turning head ❒ Twisting ❒ Walking

Patient Condition

What activities or positions relieve your condition:

❒ Heat ❒ Lying down ❒ Sitting ❒ Sitting ❒ Stretching ❒ Other
❒ Ice ❒ Medication ❒ Massage ❒ Standing ❒ Exercise

Have you ever had this condition before? ❒ Yes ❒ No If yes, when? ____

Were you treated for this condition or a similar one before? ❒ Yes ❒ No If yes, when/by whom? ______________________________

____

Health History

Do you have any allergies? (food, contact, environmental) ____

List any prescribed medications, over the counter medications, vitamins, herbs and supplements __________________________________

____

When was your last: Physical examination _______________ Blood/lab work _______________ X-ray study _______________

Injuries/Surgeries you've had and when? ____

____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below***

❒ Ankylosing spondulitis
❒ Anxiety
❒ Arthritis
❒ Asthma
❒ Bleeding disorder
❒ Blurred vision
❒ Bowel/Bladder problems
❒ Buzzing in ear
❒ Cancer
❒ Carpal tunnel
❒ Celiac disease (gluten)
❒ Chest pains
❒ Chronic fatigue
❒ Cold hands or feet
❒ Colitis/discerticulitis
❒ Compression fractures
❒ Connective tissue issues
❒ COPD (bronchitis/emphy)
❒ Depression
❒ Diabetes
❒ Digestive/bowel problems
❒ Dizziness or vertigo
❒ Fibromyalgia
❒ Fusions (spinal, joint)
❒ Gout
❒ Hear disease
❒ Hepatitis (A, B, C, etc.)
❒ Herpes
❒ High blood pressure
❒ Hip replacement
❒ HIV/AIDS
❒ Kidney disease
❒ Knee surgery
❒ Liver disease
❒ Marfan syndrome
❒ Multiple sclerosis
❒ Osteoporosis/penia
❒ Parkinson's disease
❒ Rotator cuff problem
❒ STI/STD
❒ Shoulder surgery
❒ Spinal surgery
❒ Stroke/TIA
❒ Thyroid problems
❒ Tuberculosis
❒ Other ________________________________
❒ Other ________________________________

Are there any conditions that run in your family? ❒ Yes ❒ No If yes, what condition(s) and which family member? ________________

____

Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant? ❒ Yes ❒ No If yes, how many weeks? _______________

How many hours per week do you typically work/attend school? ❒ <20 hrs ❒ 20 hrs ❒ 30 hrs ❒ 40 hrs ❒ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? ____

Do you exercise? ❒ Yes ❒ No If yes, how often and what type? ____

Do you or does anyone else ever "crack" you neck/back/joints? ❒ Yes ❒ No If yes, how often and what body parts? _______________

How would you rate your eating habits? ❒ Excellent ❒ Pretty good ❒ Could be better ❒ Needs improvement

How well do you sleep? ❒ Excellent ❒ Pretty good ❒ Restless ❒ Can't sleep ❒ Wake up often

How many hours of sleep do you get daily? _______ hours *and* Do you feel rested in the morning? ❒ Yes ❒ No

How is your energy overall? ❒ Full power ❒ OK ❒ Low ❒ Sporadic/Generally fatigued ❒ I depend on caffeine for energy

How do you feel your immune system is working? ❒ Strong ❒ OK ❒ Low

What do you hope to receive from our program? ____

Thank you for completing our health care questionnaire