PATIENT INTAKE FORM

First Name _____ **Last Name** _____

Address_____

City _____ **State** _____**Zip Code** _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ **Work Phone (_____)** ____-_____

Cell Phone (_____) _____-_____**Email**_____

Date of Birth _____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Primary Insurance Name_____
Address:_____
Insured's Name:_____
Insured's Employer:_____
Insured's SS#_____
DOB:_____
ID#_____ **Group#:**_____

Secondary Insurance Name:_____
Address:_____
Insured's Name:_____
Insured's Employer:_____
Insured's SS#_____
DOB:_____
ID#_____**Group#**_____

Your Occupation
_____

Spouse Data
First Name _____ **Last Name** _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact

Contact Name _____ Relationship _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____)_____-_____

Who can we thank for your referral to our office?_____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling

Stroke Parent Sibling
Thyroid Parent Sibling
Other _____

Occupational Activities: (Circle one that best describes your job description)

Administration Business Owner Clerical/Secretary Computer User
Heavy Equipment operator Daycare/Childcare Construction Health Care
Food Service Industry Medium Manual Labor Manufacturing
Heavy Manual Labor Light Manual Labor Executive/Legal Housekeeper
Other _____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			

Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson’s				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			

Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken

_____

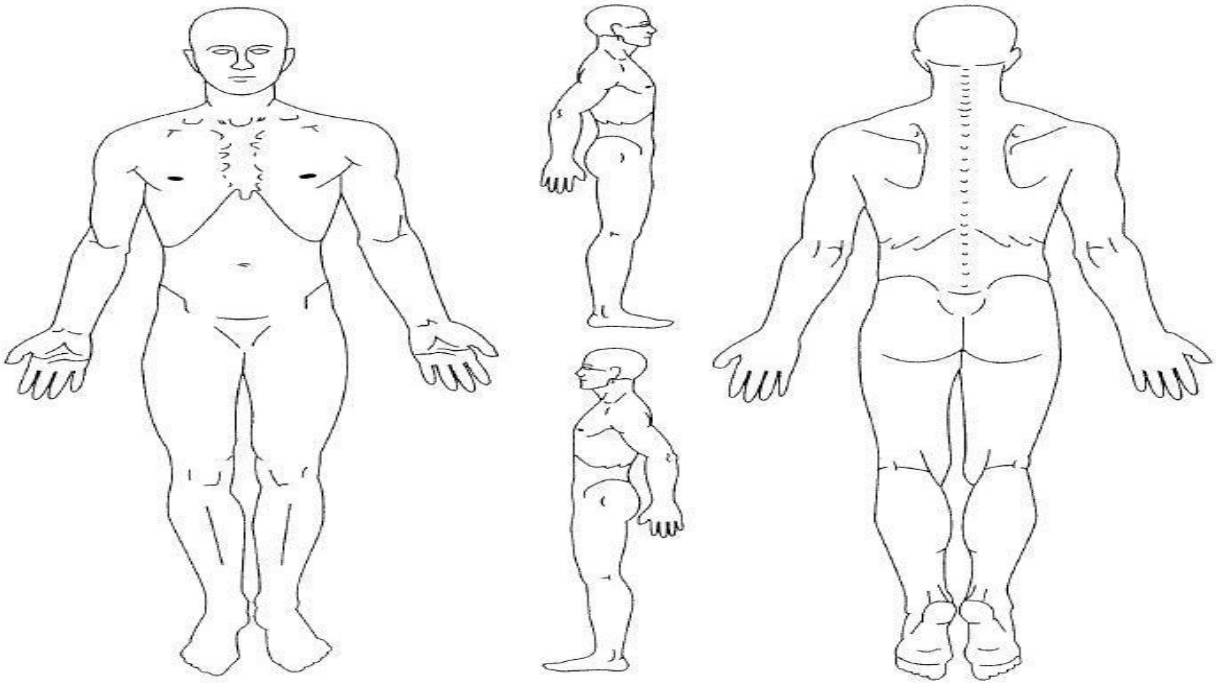
How are your symptoms changing? Getting better Not changing Getting worse

Are You Pregnant? (Circle) **Yes No**

Patient Signature_____**Date**_____

***We invite you to discuss with us any questions you might have regarding our services, or your care. The best health services are based on a friendly, mutual understanding between provider and patient.**
***I authorize the staff to perform any necessary services needed during diagnosis and treatment, and I also authorize the provider to release any information required to process insurance claim**
***I understand that the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided**

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin?

_____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin?

_____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other _____