

PATIENT INTAKE FORM

Please complete this questionnaire. This confidential history will be part of your records.

Name: _____ Birthday: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Soc. Sec. # _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

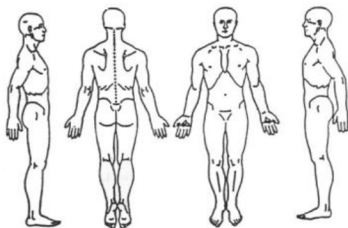
Marital Status: ☐ S ☐ M ☐ D ☐ w/children, ages: _____ Spouse's Name: _____

Insured's Name: _____ Insured's SSN: _____ Insured's DOB: _____

Your Occupation: _____ Employer: _____

Who referred you to us? _____ How else did you hear about us? _____

Indicate with an X on the drawings below where you have pain/symptoms.



List/describe the symptoms in order of severity

1 _____
2 _____
3 _____
4 _____
5 _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the time)

☐ Frequently (51-75% of the time)

☐ Occasionally (26-50% of the time)

☐ Intermittently (1-25% of the time)

How would you describe your pain?

☐ Sharp

☐ Tingly

☐ Numb

☐ Sharp with motion

☐ Diffuse

☐ Shooting

☐ Stiff

☐ Dull

☐ Achy

☐ Shooting with motion

☐ Burning

☐ Stabbing with motion

Using scale from 0-10 (10 being the worst), how would you rate your condition?

(Please circle)

0 1 2 3 4 5 6 7 8 9 10

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting worse

Is this condition interfering with activities of daily living?

☐ Work

☐ Sleep

☐ Daily Routine

☐ Other: _____

Have other doctors or therapists treated this condition? _____

Please list surgical operations and years: _____

What is your: Height _____

Weight _____

Family Physician

Name: _____

Phone Number: _____

List of Medications:

Name: _____

Dosage: _____

Frequency: _____

Name: _____

Dosage: _____

Frequency: _____

Patient's Name: _____

Medications Continued.

Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N

If yes, please describe: _____

Indicate if you have any immediate family members with any of the following:

- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Lupus
- ☐ Heart Problems
- ☐ Cancer
- ☐ ALS

Please mark any conditions that apply:

- ☐ AIDS/HIV
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Alcoholism
- ☐ Emphysema
- ☐ Measels
- ☐ Rheumatic Fever
- ☐ Allergy Shots
- ☐ Epilepsy
- ☐ Migraine
- ☐ Scarlet Fever
- ☐ Anemia
- ☐ Fractures
- ☐ Headaches
- ☐ Sexually Transm. Disease
- ☐ Anorexia
- ☐ Glaucoma
- ☐ Miscarriage
- ☐ Stroke
- ☐ Appendicitis
- ☐ Goiter
- ☐ Mononucleosis
- ☐ Suicide Attempt
- ☐ Arthritis
- ☐ Gonorrhea
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Gout
- ☐ Mumps
- ☐ Tonsillitis
- ☐ Bleeding Disorders
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Breast Lump
- ☐ Hepatitis
- ☐ Pacemaker
- ☐ Tumors, Growths
- ☐ Bronchitis
- ☐ Hernia
- ☐ Parkinson's Disease
- ☐ Typhoid Fever
- ☐ Bulimia
- ☐ Herniated Disk
- ☐ Pinched Nerve
- ☐ Ulcers
- ☐ Cancer
- ☐ Herpes
- ☐ Pneumonia
- ☐ Vaginal Infections
- ☐ Cataracts
- ☐ High Blood Pressure
- ☐ Polio
- ☐ Whooping Cough
- ☐ Chemical Dependency
- ☐ High Cholesterol
- ☐ Prosthesis
- ☐ Other _____
- ☐ Chicken Pox
- ☐ Kidney Disease
- ☐ Psychatric Care

What habits do you currently do?

- ☐ Smoking Packs/Day _____
- ☐ Alcohol Drinks/Week _____
- ☐ Coffee Cups/Day _____

What activities do you do at work?

- ☐ Sit:

☐ Most of the day

☐ Half of the day

☐ A little of the day
- ☐ Stand:

☐ Most of the day

☐ Half of the day

☐ A little of the day
- ☐ Computer Work:

☐ Most of the day

☐ Half of the day

☐ A little of the day
- ☐ On the phone:

☐ Most of the day

☐ Half of the day

☐ A little of the day

Print Patient Name: _____

Date: _____

Patient Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____