CASTELLINI CARE red bank
acupuncture
chiropractic
physical therapy
active release

www.castellinicare.net

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: _____

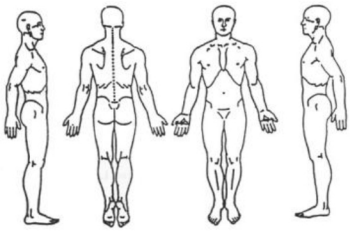
Marital Status: ❑ S ❑ M ❑ D ❑ w/children, ages: _____ Spouse's Name: _____

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) ❑Occasionally (26-50% of the time)
❑Frequently (51-75% 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 conditon: ❑ 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:

❑Rheaumatoid Arthritis ❑Diabetes ❑Lupus
❑Heart Problems ❑Cancer ❑ALS

Please mark any conditions that apply:

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

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: _____