

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.



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Name: _____ Date: _____
 Insurance: _____ (mm/dd/yr)
 Date of Birth: _____ Male female
 Address: _____

 Marital status

S	M	W	D	SEP
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 Phone #: home: _____ Cell/work: _____
 E-mail address: _____
 Occupation: _____ Family Doctor: _____

Mark (c) for current problems, check and indicate the age when you had any of the following:

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

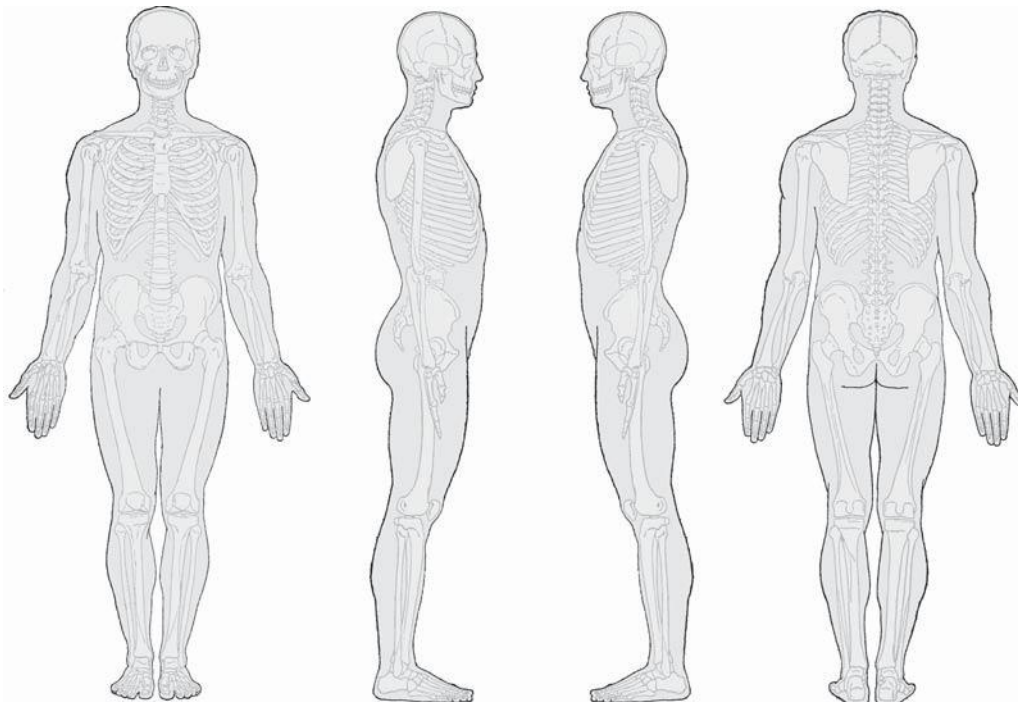
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

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

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



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any sprains or strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had a massage, if not, any interest?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
Any other Health issues?	_____		
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"/>
Meds	<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"/> Arteriosclerosis | <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 |

Patient Signature: _____

Date: _____