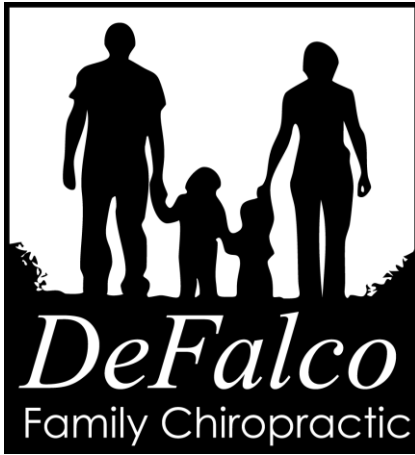


# Patient Intake Form



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male  Female

Social Security: \_\_\_\_\_ Marital Status:

Address: \_\_\_\_\_

S	M	W	D	SEP
---	---	---	---	-----

Phone #: Home: \_\_\_\_\_ Work: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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

## General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

## Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

## Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

## Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

## Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

## Genitourinary

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Pus in urine
- Stress incontinence

## Urination

- Overnight more than twice
- More than 8x in 24hrs
- Decreased flow/force
- Painful urination
- Urgency to urinate

## Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

## Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

## Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

## Menstrual flow

Reg.  Irreg.  Pain / cramps

Days of flow: \_\_\_\_\_ Length of cycle:

Date - 1<sup>st</sup> day last period:

Are you pregnant?  yes,  no

If yes, how many months?

How many children do you have? \_\_\_\_\_

Birth control method:

Date of last PAP test:

normal,  abnormal

Date of last mammogram:

normal,  abnormal

## Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

\_\_\_\_\_

\_\_\_\_\_

How Did you Hear about us: \_\_\_\_\_

# Patient Intake Form

Give a brief detailed description of the problem you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

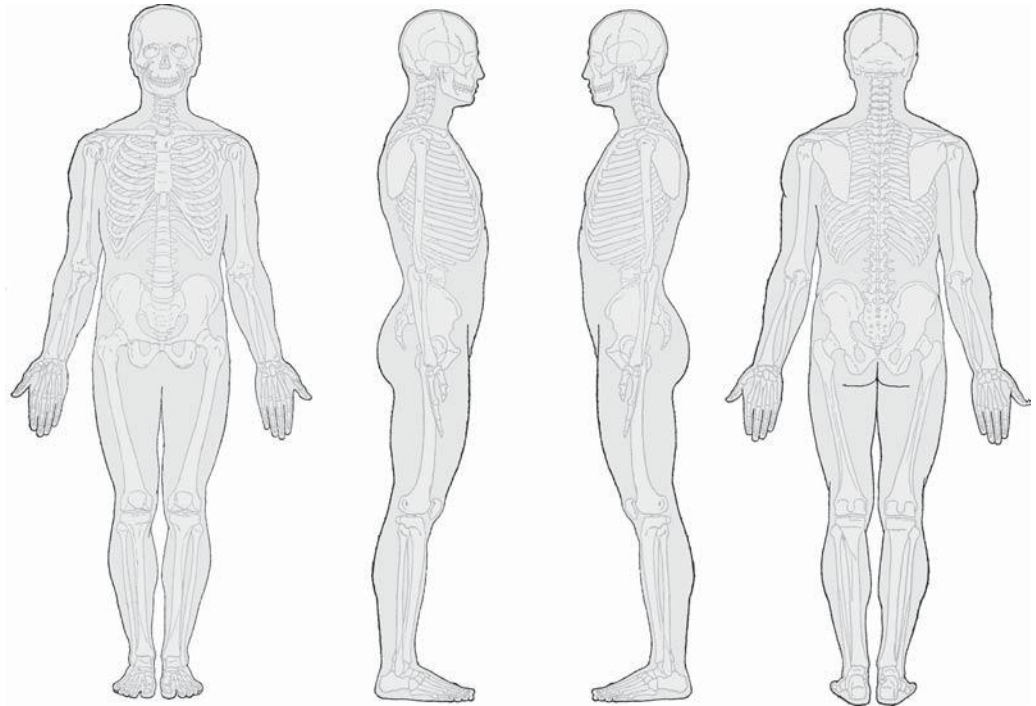
How long have you had this condition? \_\_\_\_\_ Is it getting worse?  yes  no \_\_\_\_\_

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 mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<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: _____		
How old is your mattress?	_____		
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"/>
Drugs	<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     |

Do you have any other health issues or concerns that our staff should be made aware of? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_