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Patient Intake Form

Today's Date:_____

Patient Name:_____

Address:_____

City:_____ ST:_____ Zip:_____

DOB: _____ / _____ / _____ Age:_____ Height:_____ Weight:_____

Employer: _____ Occupation: _____

☐Single ☐Married / Spouse/Partner's Name:_____

How did hear about us? _____
☐ Friend ☐ Facebook ☐ Ad ☐ TV

Telephone: _____ ☐ Cell ☐ Home ☐ Other

E-mail: _____
For Appointments

Emergency Contact Person: _____

Relationship: _____ Phone: _____

PATIENT CONDITION

Reason for Visit: _____

How did your illness/injury **happen**? _____

When did your problem **begin**? _____

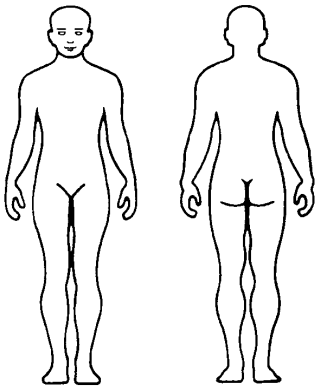
Have you had this problem before? _____

Is this condition getting: ☐ Worse ☐ No Change

Is it constant or does it come and go? _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Relationships



Mark an "**X**" on the **picture** where you continue to have Symptoms, Pain, Numbness or Tingling:

Rate the severity of your pain on a scale from **1** (least pain) to **10** (severe pain): _____

Activities or movements that worsen your condition or are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Coughing, Sneezing , Straining
☐ Exercise ☐ Repetitive Motion ☐ Overhead Activities ☐ Nothing ☐ Other:_____

What helps your problem? ☐ Rest ☐ Nothing ☐ Other: _____

When was your last medical exam? _____

What Tests have you had? ☐ Blood Test ☐ X-Rays ☐ MRI ☐ Other: _____

Are you taking Medications for this problem or any other condition(s)? _____

Why do you think the standard medical approach is not working for you? _____

How committed are you to getting well? _____

What is your health worth to you to get better? _____

HEALTH HISTORY

Medical Conditions: Please check all boxes below that apply ☐ None

☐ Cancer ☐ Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Diabetes ☐ Neuropathy

☐ Thyroid ☐ Stomach/Gut Problems ☐ Migraine/Headaches ☐ Anxiety ☐ Weight Gain ☐ Hormone Issues

☐ Auto Immune Conditions ☐ Allergies ☐ Skin Conditions ☐ Other: _____

Hospitalizations: _____ Surgeries: _____

Broken Bones, Fractures, Dislocations: _____ ☐Implants ☐Metal

Car Accidents: _____ Slips / Falls: _____

Minor Injuries? _____

What do you do at work? _____

How is your **Quality of Sleep**? _____ Hours: _____

Are you following a Special Diet? _____ ☐ Keto ☐ Paleo ☐ Vegan ☐ Fasting

Junk Food? ☐ Yes ☐ No Eat out often? ☐ Yes ☐ No Do you drink enough water? _____

☐ **Smoke**, packs/day: _____ ☐ **Alcohol**, drinks/week: _____ ☐ **Coffee/Caffeine/Energy Drinks**, cups/day: _____

☐ **High Stress?** ☐ No ☐ Yes / Reason: ☐ Family ☐ Work ☐ School ☐ Other