Intake Forms

Complementary Therapies Intake Form

Please scan or take a picture and send a copy of Drivers License and Healthcard with this intake form.

Full name:

Date of birth:

Healthcard Number:

Presenting Concern/ Diagnosis:

When did the pain or illness begin?

Did it begin gradually or suddenly?

If suddenly, is it the result of an injury? ____Yes ____No

If result of an injury, describe the injury.

If not a result of injury, what do you think caused your pain or illness?

Since your pain or illness started is it (circle one)
Worse
Unchanged
Intermittent
Better
NA

Please describe your pain or illness in as much detail as possible

Do you have any other symptoms such as numbness, weakness, or pins and needles sensation? Please describe.

What makes your pain or illness worse?
Standing_____ Sitting_____ Walking_____ Lying Down_____
Other

What have you found that makes your pain or illness better?

Does your pain or illness affect your sleeping? Yes____ No_____ If so, how

Do you have difficulty controlling your bowels? Yes ___ No___ Difficulty controlling your bladder Yes___ No___

Please mark your average (A) and maximum (M) pain level on the line below.
0 1 2 3 4 5 6 7 8 9 10
No Pain____I_____I_____I____I____I____I____I____I____I____I____I____ Worst Pain Imaginable

Was the injury work-related? Yes____ No____
Are you involved in a lawsuit? Yes ____No_____

Does the pain interfere with your ability to work? Yes____ No_____
If so, how?

Does the pain interfere with your daily activities? Yes____ No_____
If so, how?

Do you need assistance with walking? Yes____ No____
Assistive Device? _____

If yes, is this assistive device preventing falls?
Have you had any recent falls? ___Yes ___No

SUBJECTIVE ASSESSMENT OF THE HOME ACTIVITY LEVEL
Please indicate which activities of daily living cause the greatest difficulty

PERSONAL	HOUSEHOLD CHORES	GENERAL MOBILITY
Dressing upper body	Meal preparation	Sitting
Dressing lower body	Shopping	Bending
Bathing	Home Repairs	Getting in/out of bed
Hair care	House cleaning	Standing
Sleeping	Shoveling snow	Walking
Yard work/gardening	Twisting	Lifting
Child Care	Up and Down Stairs	Getting in/out of car

HISTORY OF TREATMENTS
Please indicate whether or not you have had any of these tests for your present problem:
Please indicate the following treatments you have tried in the past.

TREATMENTS	DATE	OUTCOME
Exercise		
Physical Therapy		
Occupational Therapy		
Chiropractic		
Counseling		
Biofeedback		
Injections/Nerve Block		
TENS Unit		
Medications		

HISTORY OF PAST PROVIDERS

Please list the names of all physicians, chiropractors, psychiatrist, psychologist, osteopaths, or other pain facilities whom you have seen for your present problem. List them in the order in which you saw them from first to last.

NAME OF PHYSICIAN
SPECIALTY
DATE FIRST SEEN
DATE LAST SEEN

PAST MEDICAL HISTORY
Do you have or have you had any of the following conditions? (Please Check All That Apply)

ENDOCRINE HEMATOLOGY RHEUMATOLOGY
__Diabetes __Bleeding disorder __Arthritis, Type_____
__Hypo/Hyperthyroid __Anemia __Fibromyalgia

CARDIAC GENITOURINARY GASTROINTESTINAL OTHER
__Heart Attack __Incontinence __Ulcers
__Congestive Heart failure __Bladder control problems __Gallstones __Cancer, Type_____
__Coronary Artery Disease __Kidney disease __Liver Disease _____
__Valvular heart Disease __Kidney infections __Hepatitis _____
__High Blood Pressure __Pancreatitis _____
__GERD/reflux disease _____

RESPIRATORY NEUROLOGICAL PSYCHIATRIC
__Asthma __Stroke/TIA __ Bipolar disease
__Bronchitis __Migraines __ Depression
__Emphysema/COPD __History of Drug/Alcohol problems
__Other mental illness_____
__ Anxiety

Please provide any additional about the above conditions below, or list other conditions not covered on the above
list:

PAST SURGICAL HISTORY
Please list any surgeries you have had including procedure and date:
Surgery :
Year :
Facility/Physician:

CURRENT MEDICATIONS
ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS? (e.g. ASPIRIN, COUMADIN, HEPARIN, TICLID, PLAVIX (CLOPEDIGREL) PLETAL, LOVENOX, ARISTA, JANTOVEN, WARFARIN, OTHER _____ YES_____ NO_____

Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal
preparations, laxatives, or inhalers.

Medication & Dose How often
1)
2)

3)
4)
5)
6)
7)
8)
9)

*DRUG ALLERGIES
DO YOU HAVE ANY ALLERGIES? YES NO If yes, please list the medication and the reaction:
This includes: medications, food, latex, iodine, environmental agents or irritants
Item/Drug Reaction Item/Drug Reaction

REVIEW OF SYSTEMS
Do you have any of the following symptoms? Please highlight all that apply.

• GENERAL: Weight loss, rashes, itching, color changes, headaches, dizziness, fever or chills, night sweats

• EYES: Blurred vision, light sensitivity, deficits in your vision, changes in your vision.

• EAR,NOSE,THROAT: Sinus problems, trouble swallowing, ringing in your ears, dental problems.

• CARDIAC: Chest pain, palpitations, poor circulations, swelling in extremities, poor exercise tolerance

• REPIRATORY: Shortness of breath, difficulty breathing, wheezing, coughing, sputum production.

• URINARY: Painful urination, difficulty urinating, bladder control problems, frequent urinary infections.

• GASTROINTESTINAL: Heartburn, nausea, vomiting, diarrhea, bloody stools, constipation.

• MUSCULOSKELETAL: Achy swollen joints, stiff joints, muscle spasms, sore/ tender muscles.

• SKIN: Rashes, skin irritations, skin ulcers.

• NEUROLOGICAL: Poor memory, headaches, poor balance, loss of consciousness, fainting, muscle weakness, numbness, or changes in sensation.

• PSYCHOLOGICAL: Anxiety, depression, increased emotional stress, hallucinations, paranoia, suicidal ideations (thoughts of harming yourself difficultly with concentration.

• ENDOCRINE: Always thirsty, always hot, always cold, hair and nail changes.

• HEMATOLOGY: Easy bruising, cuts take a long time to stop bleeding, painful lymph nodes, frequent leg swelling, fatigue.

• ALLERGIC/IMMUNE: are you prone to infections, sensitive to many foods, medicines
FAMILY HISTORY

Please list any significant medical problems for any blood relatives(parents, grandparents, brothers or sisters) also list any medical problems that tends to run in your family.

SOCIAL HISTORY
Marital Status: Single___ Married____ Divorced____ Widowed____
Indicate current household members: Self____ Spouse____ Children____ Other____
What kind of support do you have to help you cope with this problem? (e.g. family, friends, church, etc.)

EXERCISE:
Type of exercise:_____
Days/Week:_____
TOBACCO USE: Do you currently use tobacco products? ____Yes ____NO
IF YES, how many packs a day? _____ How many years?_____
IF FORMER SMOKER, when did you quit?_____
Before you quit, how many packs a day ___ and how many years_____
Do you drink caffeinated beverages? YES NO If yes, how many cups/cans per day? _____
Do you drink alcoholic beverages? YES NO
If yes, how many beverages per week? _____

Have you ever had, or do you have a substance abuse problem? Yes___ No__

Are you currently employed? ___Yes ___No.
If yes please complete the following questions:

Your current occupation
_____
Your usual duties include:
_____

Are you involved with Workman's compensation? ____Yes ____No

OTHER
Is there any chance you could be pregnant? YES NO If yes, when is your due date?

Primary Language: English Spanish Other_____ Do you need an interpreter? YES NO

Are you hard of hearing? YES NO Do you need glasses to read? YES NO

Would you like to have a consult with a dietician to discuss any dietary concerns? YES NO

Are there any religious or cultural factors which may impact your care while in the clinic? YES NO
If yes, please
explain_____

Do you, or anyone you know, need information regarding problems of abuse and/or neglect? Yes _____
No _____

What are your realistic goals for treatment of your pain? (check all that apply)
To be pain free ____ Help living with pain ____ Other _____
Reduced pain _____ Increased activity _____

Thank you for your time in completing this form

Patient signature (e-signature is completed by copying and pasting the entire form into an email to colletthumanservices@hotmail.com and writing PATIENT INTAKE FORM in the subject line)

NAME:____________________________ DATE:____________________________________