Patient Intake Form

Name: _____

- Presenting Problem: _____
- Have you seen other providers for the current issue:

  None___ Physiotherapy___ Massage Therapy___ Physician_____
  Acupuncture_____ Chiropractor__ Others_____
- Have they provided any results: _____

Have you RECENTLY noted any of the following (check all that apply)?

changes in bowel function/control
changes in bladder function/control
weight loss/gain
fever/chills/sweats nausea/vomiting
shortness of breath
pain at night
speech problems
vision problems
hearing problems
current pregnancy (suspected)
dizziness/lightheadedness
headaches
weakness/fatigue
difficulty maintaining balance while walking
changes in appetite
difficulty swallowing
recent, unexplained abdominal pain
recent, recurrent infection
numbness
involuntary movements
sustained morning stiffness
shortness of breath
constipation/bloated
changes in fingernails
chronic cough
snoring/sleep apnea
nasal congestion/post nasal drip
heat or cold intolerance
excessive thirst or sweating
rash/dry skin/redness of skin
problem sleeping
memory problems
spaciness, fogginess in the head
clumsiness/poor coordination
Confuse left and right easily
Ambidextrous (use left & right)
Born low birth weight / premature
Born with birth complications
Born by C-section
Walked quickly or delayed
Serious childhood illness
Fear of crowds / claustrophobia
Hormonal problems
Menopause year: _____
Changes in menstruation pattern
reduced concentration/attention

ALLERGIES: _____ Are you latex sensitive? Yes – No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

Have you EVER been **diagnosed** with any of the following conditions (check all that apply)?

cancer (type)_____
kidney problems
Liver problems
Arthritis
Rheumatoid arthritis
Diabetes
Heart disease
Stroke
multiple sclerosis
high blood pressure
depression
anemia
stomach
ulcers
pacemaker inserted
lung problems
epilepsy
osteoporosis
thyroid problems
Parkinson's disease
Chemical dependency (i.e., alcoholism)
Lupus
Concussion
Fibromyalgia
Acid Reflux
Irritable Bowel Syndrome
Other Digestive issues_____
ADHD/ADD
Dyslexia
Spinal Cord Trauma
Asthma
Blood Disorders
other_____

Medications - Please list and medications you are taking and why:

○ **Medications:**	○ **Why:**
○	○
○	○
○	○

- Have you been taking steroids for long time? Yes – No
- Are you currently taking Blood Thinning (Anti-Coagulant) medications for any medical conditions? Yes – No
- What types of medical diagnostic testing have you had done to date (e.g. X-Ray, MRI, CT scan, bone scan, blood work)? _____

Family History - If any blood relatives has had any of the following, please check and indicate which relative(s)

Alcoholism	Cancer	High blood pressure
Anemia	Diabetes	High cholesterol
Arteriosclerosis	Emphysema	Multiple sclerosis
Arthritis	Epilepsy	Osteoporosis
Asthma	Glaucoma	Stroke
Bleed easily	Heart disease	Thyroid disease

- Do you think that stress impact your symptoms? Yes - No
- Do you sleep well? Yes - No
- During the past month have you been feeling down, depressed or hopeless? Yes - No
- During the past month have you been bothered by having little interest or pleasure in doing things? Yes - No
- Do you smoke? (if yes, how many packs a day_____) Yes - No
- How long did you have the current symptoms? (weeks/months/years)_____
- How did your symptoms start? (sudden/slow/recurrent/accident)_____
- Are your symptoms constant? Yes – No
- During a normal day, when are your symptoms worse? _____
- Are the symptoms activity related? (gets worse with activity) Yes - No
- Do your symptoms improve with rest? Yes - No
- What makes your symptoms better? (if any)

  _____

  What makes your symptoms worse? (if any)

  _____
- Are you sensitive to any smell or taste? Yes - No

BodyChart:

Symptoms at LOWEST: Rate you lowest symptom level in past 24 hrs.

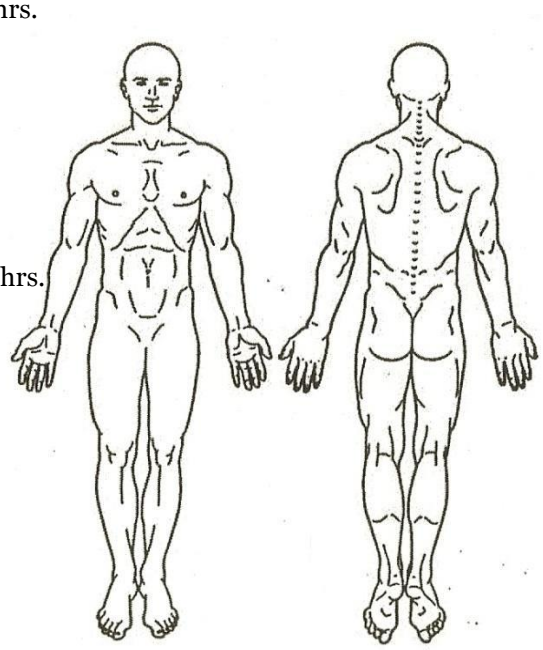
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

Symptoms Currently: Rate your level of symptom at this time.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

Symptoms at WORST: Rate your highest symptom level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable



Please mark the location of your pain, (or other symptom) with appropriate descriptor on the chart:

X	Sharp stabbing pain
O	Dull achy pain
....	Numb/Tingling
///	Throbbing
==	Burning
|	electricity/shooting

Do you understand your diagnosis? Yes - No

What is your GOAL FOR THERAPY at this time?_____