DISCOVER soft tissue+spine

New / Returning Patient Intake Form

Date	I.D. #

Please fill out all the information. We cannot begin the consultation until this form is fully completed

Patient's Full Name: ______________________________ Age:________ Sex: ❑M ❑F

How would you like to be addressed by our staff? ______________________ Date of Birth: ______________

Address: ______________________________ City: ______________ State:______ Zip: ____________

Phone (Home):____________________(Work):______________________(Cell):____________________

Which phone number is your preferred method of contact: ❑ Home ❑ Work ❑ Cell

Email Address:______________________________ Marital Status: ❑S ❑M ❑D ❑W Number of Children: ______

I give you permission to email me appointment reminders, newsletters, birthday cards, etc. ❑Yes ❑No

Occupation: ____

Employer: ______________________________ Driver's License Number: ______________________

Emergency Contact's Name: ______________________ Relationship:______________________

Phone:____________________ City: ______________ State:____________ Zip: ______________

Medical Doctor's Name: __________________ Affiliation: ❑Spectrum ❑Metro ❑Mercy – St. Marys ❑Other: ________

Phone:__________________ City: ________________ State______ Zip: ______________

I give you permission to send my Medical Doctor a report regarding my diagnosis/care. ❑Yes ❑No

How did you hear about this office: __________________ Referred by: ______________________________

IF YOU HAD A MAGIC WAND, WHICH PAIN AREA WOULD YOU GET RID OF?

What ONE AREA hurts? ____

How bad is the pain on a scale from 0-10
(0 = no pain 10 = worst pain ever)

Currently __________

On Average __________

Worst Ever __________

Please mark on the images where you are feeling the pain

When did your symptoms begin?

Date:____________________

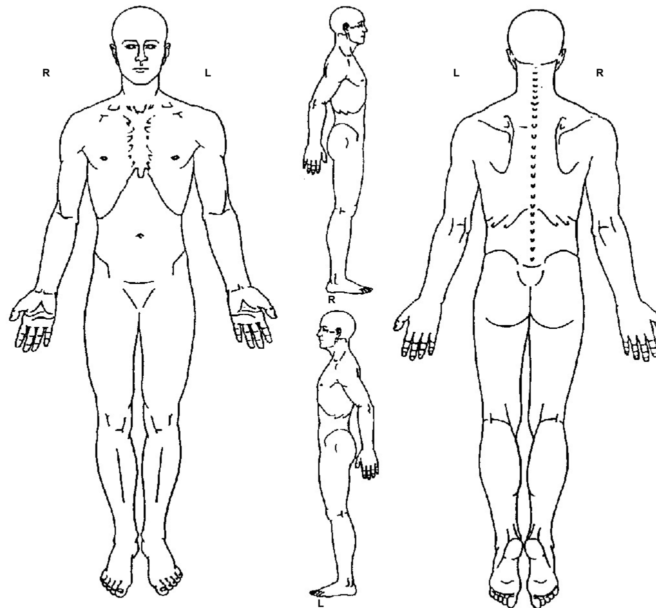
☐ Immediately after a specific incident

☐ After multiple incidents

☐ Gradually developed over time

☐ Other ____________________

PLEASE CIRCLE THE AREA BELOW TO INDICATE THE LOCATION OF YOUR SYMPTOMS



PLEASE CHECK WHAT SYMPTOMS ARE YOU EXPERIENCING:

❑ **ACHING**

❑ **BURNING**

❑ **NUMBNESS/TINGLING**

❑ **PINS & NEEDLES**

❑ **STABBING**

❑ **SHARP**

❑ **STIFFNESS**

❑ **THROBBING**

❑ **OTHER** __________

____

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What caused the pain: ☐no apparent cause ☐one incident____

Since the onset, has it gotten: ☐Worse ☐Stayed same ☐Better

Has this pain occurred before: ☐Yes ☐No How long ago since first occurrence? ___________ months / years ago

Do you feel pain sitting here, RIGHT NOW, WITHOUT MOVING, **at REST**? ☐Yes ☐No If yes, how intense is it from 0-10? _______

What makes the pain **WORSE**? ____

☐Nothing ☐Lying down ☐Standing ☐Sitting ☐Movement/Exercise ☐Other ______________________________________

How long (in mins or hours) do you have to do the above activity before it gets **WORSE**? ______________________________

The symptoms are:

Better in the:	**Worse in the:**	**Frequency of symptoms:**	**Does it interfere with your daily activities:**
☐ first wake up	☐ first wake up	☐ Intermittent (25% or less)	☐ minimal (annoyance, no impairment)
☐ morning	☐ morning	☐ Occasional (26 – 50%)	☐ slight (tolerated, some impairment)
☐ afternoon	☐ afternoon	☐ Frequent (51 – 75%)	☐ moderate (marked impairment)
☐ evening	☐ evening	☐ Constant (76 – 100%)	☐ severe (preclude any activity)
☐ nighttime	☐ nighttime		
☐ none	☐ none		

If you feel it more in the morning, **how much time** does it take until it gets better? ______________________________

What activities are you prevented from performing due to your pain? ____

What makes the pain feel **BETTER**?____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? ______________________________

What is your BIGGEST concern about your pain? ____

Is there anything else I should know? ____

Are your present problems due to an injury? ❑Yes ❑No ❑On Job ❑Auto Accident ❑Personal Injury ❑Other: __________

Has the accident been reported? ❑Yes ❑No ❑To Employer ❑Auto Carrier ❑Other:___________________________

What type of physical activity do you do? ☐Weights ☐CrossFit ☐Walking ☐Running ☐Spinning ☐Yoga ☐Other______________

How many days per week do you exercise? ___________

What is your athletic history (middle, high school, college, post-college)? ____

Secondary or related complaint(s) if any: ____

PAST INJURY/DISEASE HISTORY

Have you been treated for your CURRENT problem in the past? ☐Yes ☐No

If yes, when: _______________ If yes, by whom: ____

Outcome: ☐No effect ☐Somewhat better ☐Resolved

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Have you been treated for **OTHER** (back pain, neck pain, etc.) problems in the past? ☐Yes ☐No

If yes, when: __________________ If yes, by whom: ____

Outcome: ☐No effect ☐Somewhat better ☐Resolved

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents (sports or auto), or surgeries:

DATE	Injury / Fracture / Illness / Surgery / Fall	Treatment	Result

What is your current work status?

❑Full time, no restrictions ❑Full time, restrictions ❑Full time Homemaker ❑Full time student ❑Part time, no restrictions
❑Part time, restrictions ❑Retired ❑Unemployed ❑Off work due to restrictions ❑Other ___________________________

Have you ever had X-rays taken? ❑Yes ❑No When? __________________ By Whom? ______________________________

For what ailments were these X-rays made? ____

Do you wear orthotics or heal lifts? ❑Yes ❑No Fitted by whom? ___________________________ When? _______________

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ___________________

Are you presently taking **any medication, prescription, over-the-counter, home remedies, vitamins, minerals**, etc? (Please list)

Please check the box for each item below you have had, or currently have, with approximate dates.

DATE MUSCULO-SKELETAL

______ ❑ Painful Joints
Where______________
______ ❑ Osteoporosis
______ ❑ Muscle Spasms/Cramps
Where______________
______ ❑ Other
______ ❑ Stiff Neck
______ ❑ Spinal Curvature
______ ❑ Swollen Joints
______ ❑ Arthritis Pain
Where______________
______ ❑ Scoliosis

DATE CARDIO-VASCULAR

______ ❑ High Blood Pressure
______ ❑ Low Blood Pressure
______ ❑ Heart Disease
______ ❑ Chest Pain
______ ❑ Poor Circulation
______ ❑ Rapid Heart
______ ❑ Slow Heart
______ ❑ Strokes
______ ❑ Abnormal Swelling
______ ❑ Varicose Veins
______ ❑ Palpitations

DATE SKIN OR ALLERGIES

______ ❑ Bruising Easily
______ ❑ Dryness
______ ❑ Eczema
______ ❑ Hives or Allergy
______ ❑ Itching
______ ❑ Sensitive Skin

DATE EMOTIONAL/MENTAL

______ ❑ Nervousness
______ ❑ Anxiety
______ ❑ Mild Depression
______ ❑ Clinical Depression
______ ❑ Panic Attacks

DATE GENERAL SYMPTOMS

______ ❑ Allergy (what)
____
____
______ ❑ Loss of Sleep
______ ❑ Chills (Constant)

DATE RESPIRATORY

______ ❑ Chest Pain
______ ❑ Chronic Cough
______ ❑ Difficulty Breathing
______ ❑ Asthma
______ ❑ Bronchitis

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Cont… Please check the box for each item below you have had, or currently have, with approximate dates

DATE	NEUROLOGICAL	DATE	GASTRO-INTESTINAL	DATE	NOSE/THROAT/EYE/EAR	DATE	GENITO-URINARY
______	❑ Migraines	______	❑ Belching	______	❑ Impaired Hearing	______	❑ Bed Wetting
______	❑ Headaches	______	❑ Colon Trouble	______	❑ Deafness	______	❑ Blood in Urine
______	❑ Bell's Palsy	______	❑ Constipation	______	❑ Earache	______	❑ Frequent Urination
______	❑ Paralysis	______	❑ Diarrhea	______	❑ Ear Discharge	______	❑ Inability to Control Urine
______	❑ Seizures	______	❑ Gall Bladder Trouble	______	❑ Ear Noises		
______	❑ Dizziness/Vertigo	______	❑ Hemorrhoids (piles)	______	❑ Thyroid Problems	______	❑ Kidney Infection
______	❑ Epilepsy	______	❑ Jaundice	______	❑ Frequent Colds	______	❑ Kidney Stones
______	❑ Loss of Balance	______	❑ Liver Trouble	______	❑ Hay Fever	______	❑ Painful Urination
______	❑ Numbness/Tingling	______	❑ Nausea/Vomiting	______	❑ Nasal Obstruction	______	❑ Prostate Trouble
Where:		______	❑ Stomach Pain	______	❑ Nose Bleeds	**DATE**	**FOR FEMALES ONLY**
❑right arm ❑left arm		______	❑ Bloating	______	❑ Eye Pain/Strain	______	❑ Cramps
❑right hand ❑left hand		______	❑ Vomiting Blood	______	❑ Impaired Vision	______	❑ Hot Flashes
❑right leg ❑left leg		______	❑ Heart Burn	______	❑ Blurred Vision	______	❑ Irregular Cycle
______	❑ Twitching	______	❑ Bloody Stools	______	❑ Sinus Problems	______	❑ Painful Periods
DATE	**Energy & Immunity**	______	❑ Acid Reflux	______	❑ Sore Throats	Pregnant at this Time	
______	❑ Fatigue	______	❑ Irritable Bowel	______	❑ Tonsillitis	❑Yes ❑No	
______	❑ Fatigue After Exercise	**DATE**	**Endocrine**	**DATE**	**Endocrine Cont.**	**DATE**	**Other Conditions**
______	❑ Easy Bruising	______	❑ Hypothyroidism	______	❑ Night Sweats	______	❑ Cancer
______	❑ Frequent Flu or Cold	______	❑ Hyperthyroidism	______	❑ Unusual Sweating	Type: ______________	
______	❑ Chronic Infections	______	❑ Hypoglycemia	______	❑ Loss of Hair	______	❑ Anemia
______	❑ Autoimmune Disease	______	❑ Diabetes Type I	______	❑ Other:	______	❑ Insomnia
_________________________		______	❑ Diabetes Type II	_________________________		Other: ______________	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? (PLEASE CHECK ANY OR ALL THAT APPLY)

❑Appendicitis	❑Hepatitis	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Leukemia	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lymphoma	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Atrial Fibrillation	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

LIFESTYLE

HABITS		EXERCISE
❑Smoking	Packs/day: _____	❑None
❑Drinking	Alcohol: (Cups/day) _____	❑Moderate
❑Recreational Drugs	Amount: ________	❑Daily
❑Coffee	Cups/Day: ________	Type: __________
❑Soft Drink	Bottles or Cans/Day: _____	______________
❑Water	Cups/Day: ________	

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back	Heart
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother(s), # of ___	❑	❑	❑	❑	❑
Sister(s), # of ____	❑	❑	❑	❑	❑

Average Hours of Sleep a Night ________Hours

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. I understand that this office/provider does not participate with any insurance company except Federal Medicare. Payment is due at time of service and any amount authorized to be paid by an insurance company directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that any unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers to secure the payment of benefits.

I hereby authorize the doctor or therapist to examine and treat my condition as he/she deems appropriate, and I give authority for these procedures to be performed.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature: ____ **Date**: ____________________

Guardian Signature Authorizing Care: _____________________________________ **Date:** ____________________