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Patient Intake Form

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

Date	I.D. #

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

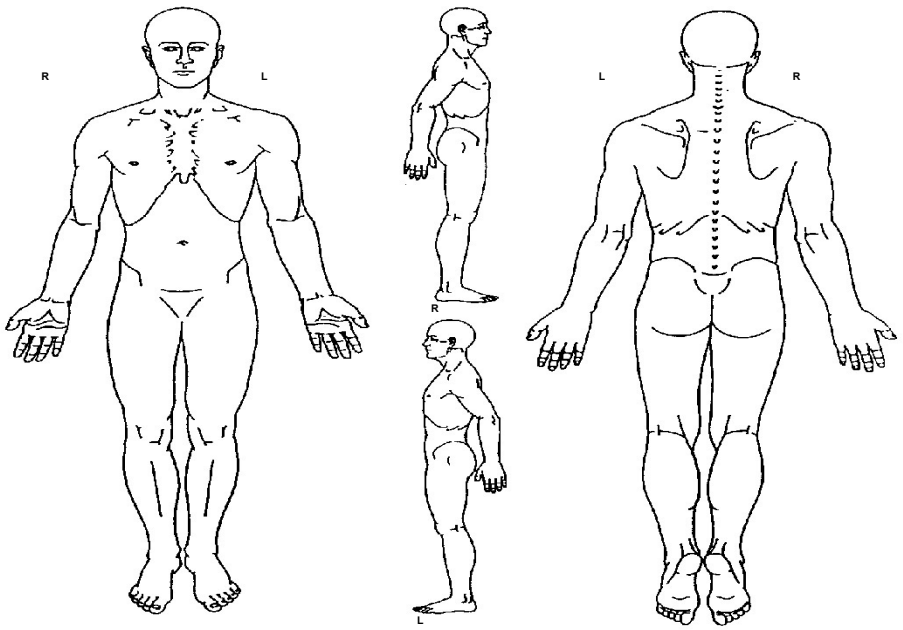
☐After multiple incidents

☐Gradually developed over time

☐Other _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS

KEY: A = ACHING B = BURNING N = NUMBNESS/TINGLING P = PINS & NEEDLES S = STABBING/SHARP X = STIFFNESS T = THROBBING O = OTHER



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 as the day goes on
☐ worse as the day goes
☐ more prevalent at night
☐ more prevalent in the morning

Does it interfere with your daily activities:
☐ minimal (annoyance, no impairment)
☐ slight (tolerated, some impairment)
☐ moderate (marked impairment)
☐ severe (preclude any activity)

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
_____	❑ Mirgraines
_____	❑ Headaches
_____	❑ Bell's Palsy
_____	❑ Paralysis
_____	❑ Seizures
_____	❑ Dizziness/Vertigo
_____	❑ Epilepsy
_____	❑ Loss of Balance
_____	❑ Numbness/Tingling

Where:

❑right arm ❑left arm
❑right hand ❑left hand
❑right leg ❑left leg

_____	❑ Twitching

DATE	Energy & Immunity
_____	❑ Fatigue
_____	❑ Fatigue After Exercise
_____	❑ Easy Bruising
_____	❑ Frequent Flu or Cold
_____	❑ Chronic Infections
_____	❑ Autoimmune Disease

_____

DATE	GASTRO-INTESTINAL
_____	❑ Belching
_____	❑ Colon Trouble
_____	❑ Constipation
_____	❑ Diarrhea
_____	❑ Gall Bladder Trouble
_____	❑ Hemorrhoids (piles)
_____	❑ Jaundice
_____	❑ Liver Trouble
_____	❑ Nausea/Vomiting
_____	❑ Stomach Pain
_____	❑ Bloating
_____	❑ Vomiting Blood
_____	❑ Heart Burn
_____	❑ Bloody Stools
_____	❑ Acid Reflux
_____	❑ Irritable Bowel

DATE	Endocrine
_____	❑ Hypothyroidism
_____	❑ Hyperthyroidism
_____	❑ Hypoglycemia
_____	❑ Diabetes Type I
_____	❑ Diabetes Type II

DATE	NOSE/THROAT/EYE/EAR
_____	❑ Impaired Hearing
_____	❑ Deafness
_____	❑ Earache
_____	❑ Ear Discharge
_____	❑ Ear Noises
_____	❑ Thyroid Problems
_____	❑ Frequent Colds
_____	❑ Hay Fever
_____	❑ Nasal Obstruction
_____	❑ Nose Bleeds
_____	❑ Eye Pain/Strain
_____	❑ Impaired Vision
_____	❑ Blurred Vision
_____	❑ Sinus Problems
_____	❑ Sore Throats
_____	❑ Tonsillitis

DATE	Endocrine Cont.
_____	❑ Night Sweats
_____	❑ Unusual Sweating
_____	❑ Loss of Hair
_____	❑ Other:

_____

DATE	GENITO-URINARY
_____	❑ Bed Wetting
_____	❑ Blood in Urine
_____	❑ Frequent Urination
_____	❑ Inability to Control Urine
_____	❑ Kidney Infection
_____	❑ Kidney Stones
_____	❑ Painful Urination
_____	❑ Prostate Trouble

DATE	FOR FEMALES ONLY
_____	❑ Cramps
_____	❑ Hot Flashes
_____	❑ Irregular Cycle
_____	❑ Painful Periods

Pregnant at this Time
❑Yes ❑No

DATE	Other Conditions
_____	❑ Cancer

Type: _____

_____	❑ Anemia
_____	❑ Insomnia

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

❑Smoking Packs/day: _____
❑Drinking Alcohol: (Cups/day) _____
❑Recreational Drugs Amount: _____
❑Coffee Cups/Day: _____
❑Soft Drink Bottles or Cans/Day: _____
❑Water Cups/Day: _____

EXERCISE

❑None
❑Moderate
❑Daily
Type: _____
_____

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**: _____

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