Patient Initial Intake Form

Patient Name:_____________________________________ SSN:________ - _______ - ________ DOB: _______/______/_______
Address:____ City:___________________ State:________ Zip Code:____________
Cell Phone: _________________________ Work Phone: ________________________ Home Phone: _______________________
E-mail address:____
Occupation:____ How long have you worked there?________________________
What type of activities are performed: ____
Spouse's Name:____ Spouse's Work Phone:_________________________________
Spouse's Occupation:______________________ Number of Children:_____________ Children's Ages:______________________
How did you hear about us?____

Primary Complaint:____
When did this complaint begin?_________________________
What makes it better?____
What makes it worse?____
If you are experiencing pain, is it: ☐ Sharp ☐ Dull-ache ☐ Burning ☐ Throbbing ☐ Stabbing
☐ Shooting ☐ Numbness ☐ Tingling ☐ Comes & Goes ☐ Constant
How often does this complaint occur? ☐ Hourly ☐ Daily ☐ Weekly ☐ Occasionally ☐ N/A
If the pain travels, where does it go?____
What time of day is it better? ☐ AM ☐ PM ☐ N/A What time of day is it worse? ☐ AM ☐ PM ☐ N/A
How long do episodes last? ☐___ Minutes ☐___ Hours ☐ All Day ☐ Never goes away ☐ N/A ☐ Wake you up
Since onset has the complaint ☐ Improved ☐ Worse ☐ About the Same ☐ N/A
Has this affected your life and/or kept you from … ☐ Working ☐ Good Home Life ☐ Sports/Hobbies ☐ Driving
☐ Spending Quality Time with Family ☐ Other ___________________

Secondary Complaint:______________________________________ When did this complaint begin?_________________________
What makes it better?____
What makes it worse?____
If you are experiencing pain, is it: ☐ Sharp ☐ Dull-ache ☐ Burning ☐ Throbbing ☐ Stabbing
☐ Shooting ☐ Numbness ☐ Tingling ☐ Comes & Goes ☐ Constant
How often does this complaint occur? ☐ Hourly ☐ Daily ☐ Weekly ☐ Occasionally ☐ N/A
If the pain travels, where does it go?____
What time of day is it better? ☐ AM ☐ PM ☐ N/A What time of day is it worse? ☐ AM ☐ PM ☐ N/A
How long do episodes last? ☐___ Minutes ☐___ Hours ☐ All Day ☐ Never goes away ☐ N/A ☐ Wake you up
Since onset has the complaint ☐ Improved ☐ Worse ☐ About the Same ☐ N/A
Has this affected your life and/or kept you from … ☐ Working ☐ Good Home Life ☐ Sports/Hobbies ☐ Driving
☐ Spending Quality Time with Family ☐ Other _____________________

- Are you currently taking any **medications**? _____ Yes _____ No
  - If yes, what medications are you currently taking?____
- Are you currently taking any **vitamins**? _____ Yes _____ No
  - If yes, what vitamins are you currently taking?____
- Have you ever been in or experienced any **accidents** or **trauma**? _____ Yes _____ No
  - If yes, what and when was it and what area of your body was injured?______________________________________
- Have you ever been **hospitalized**? _____ Yes _____ No
  - If yes, when and for what?____
- Please list any **surgeries** and/or **implants** you have undergone :

  ____

Primary Care Physician Dr. Name: ____

Date of Last Examination: ________________ Have You Been Treated For Any Conditions in the Past Year? ☐ Yes ☐ No

If Yes, Please Explain: ____

Below are a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Please mark **S** for self or **F** for family member.

Musculo - Skeletal

____ Low Back Pain
____ Pain Between Shoulders
____ Neck Pain
____ Arm Pain
____ Leg Pain/Sciatica
____ Carpel Tunnel
____ Headaches
____ Migraines
____ Scoliosis
____ Osteoarthritis
____ Rheumatoid Arthritis
____ Poor Posture
____ Joint pain
____ Swollen joints
____ Birth Trauma

Nervous System

____ Nervousness
____ Anxiety
____ Numbness/Tingling
____ Shooting Pain/Radiculopathy
____ Paralysis
____ Dizziness/Vertigo
____ Forgetfulness
____ Seizures
____ Loss of Balance
____ Loss of Smell
____ Loss of Taste

EENT

____ Vision Problems
____ Dental Problems
____ Hearing Difficulty
____ Ear Aches/Ringing/Infections
____ Nose Bleeds
____ Sinus Problems
____ Asthma/Bronchitis

Cardiovascular

____ Chest Pain
____ Cold Extremities
____ Heart Problems
____ Blood pressure Problems
____ Arterio/Athero sclerosis
____ Anemia
____ Varicose Veins
____ Stroke

Gastrointestinal

____ Poor Appetite
____ Excessive Appetite
____ Increased Thirst
____ Ulcers
____ Nausea
____ Vomiting
____ Diarrhea
____ Constipation
____ Bloating/Gas
____ Digestive Issues
____ GERD/Acid Reflux
____ Stomach Cramping
____ Bad Breath
____ Heartburn
____ Gall Stones

General

____ Allergies
____ Fatigue
____ Insomnia
____ Depression
____ ADD/ADHD
____ Colic
____ Lung Problems
____ Cancer
____ Diabetes
____ Autism
____ Heart Disease
____ Polio
____ Chicken Pox
____ Herpes Zoster/Simplex

Genitourinary

____ Kidney Infection
____ Kidney Stones
____ Frequent Urination
____ Painful Urination
____ Discolored Urination
____ Bladder Trouble
____ Impotence
____ Prostrate Problems
____ Decreased Sex Drive
____ Hemorrhoids
____ Fibroids
____ Cysts
____ Excessive Menstruation
____ Painful Menstruation
____ Endometriosis
____ Hot Flashes
____ Cramps
____ PMS
____ STD's
____ Pregnant

Is there any additional information you feel as if you need to express that has not been covered in this questionnaire?

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____

The statements made as to the questions asked on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form and in this file will remain confidential to myself, the doctor, and any other authorized personnel.

Signature: ____ **Date:** _________________________