Patient Intake Form

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer Data _____

Employer _____

Your Occupation _____

Spouse Data _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

Doctor's Signature _____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Other _____

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

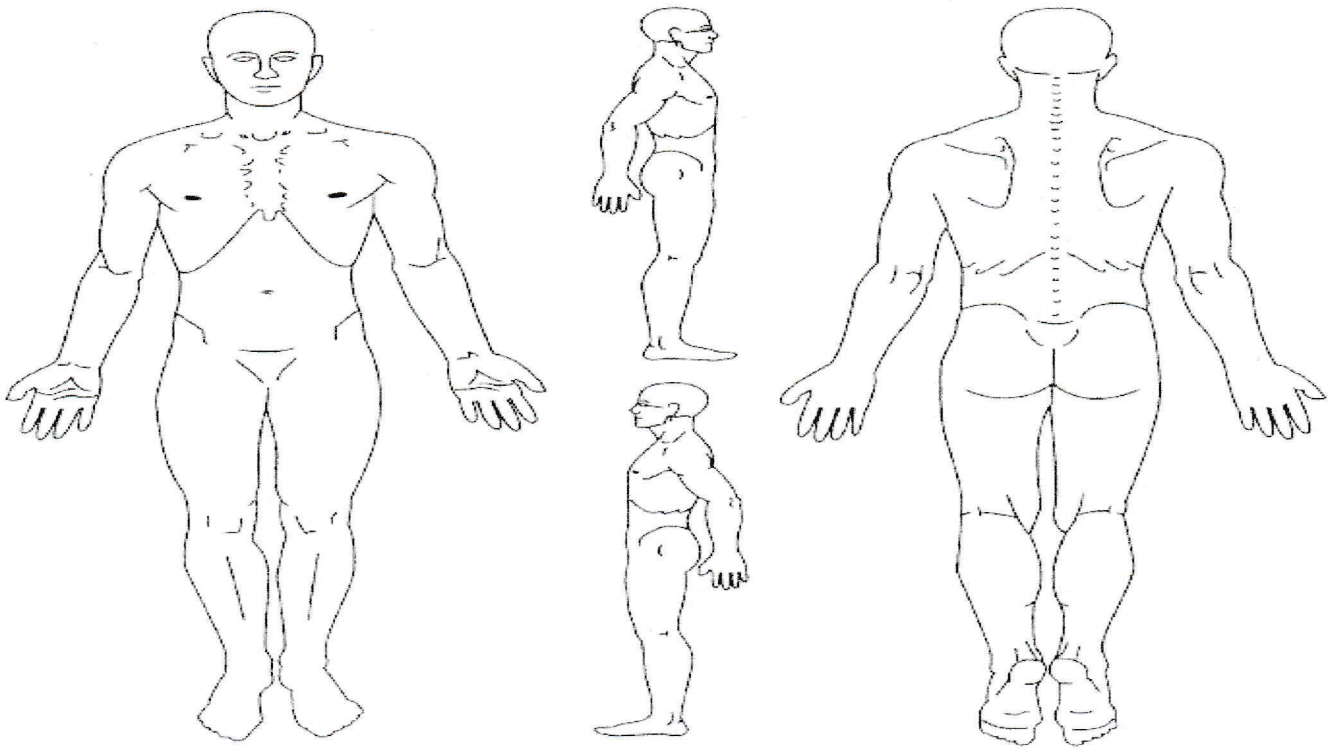
Doctor's Signature _____

Patient Name_____Date_____

Patient Name_____ **Date**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other _____

Doctor's Signature _____

Patient Name_____ Date_____