PATIENT INTAKE FORM

PATIENT INFORMATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | | Date: | | Age: |
| Date of Birth: | | Occupation: | | ❑ Male  ❑Female |
| Height: | | Weight: | | How did you hear about us? |
| Address: | | | |
| Home Phone #: | Cell #: | | Email: | |

HEALTH HISTORY

Primary concerns/complaints, in order of importance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current health problems/Past health problems (with date):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Are you experiencing pain/discomfort in any area of your body? **Y / N**  If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:  XXX Sharp/ Stabbing  P P P Pins & Needles  DDD Dull/ Aching  NNN Numbness |
|  |

FAMILY HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Check if applicable | Father | Mother | Siblings | Grandparents | Child(ren) |
| Heart disease |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| Hypertension |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Other mental illness |  |  |  |  |  |
| Substance abuse |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |
| Diabetes |  |  |  |  |  |

