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):

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

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| --- |
| 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/ StabbingP P P Pins & NeedlesDDD Dull/ AchingNNN 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  |  |  |  |  |  |

