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Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name _____ Sex ☐ F ☐ M Date _____

Date of birth _____ Age _____ Occupation _____

Address _____ City _____ State _____ ZIP _____

Main phone number _____ Other phone number _____

E-mail address _____ Allow email contact ☐ Yes ☐ No

Relationship status _____ Children _____ Family physician _____ Chiropractor _____

Emergency contact name _____ Phone number _____

How did you find out about us? ☐ Friends/relatives (Name) _____

☐ Direct mail ☐ Location ☐ Website ☐ Yellow pages ☐ Periodicals ☐ Other _____

Main problem(s)

What is/are your main problem(s)? _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____ What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was made)

Surgeries: _____ Hospitalization: _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental): _____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type?)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or Anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Occupation: _____ Do you usually work ☐ indoors ☐ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal Data

Height _____ Weight now _____ Weight one year ago _____ Weight maximum _____ @Year _____

Do you smoke? ☐ Yes ☐ No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program: _____

How many hours do you sleep in general? _____ What time do you usually go to bed? _____

Diet

How much coffee do you drink? _____ cups/day Colas? _____ number/day Tea? _____ cups/day Water? _____ glasses/day

What kind of alcoholic beverages do you drink, if any? _____ Average number of drinks/week? _____

Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict Do you eat a lot of spicy food? ☐ Yes ☐ No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

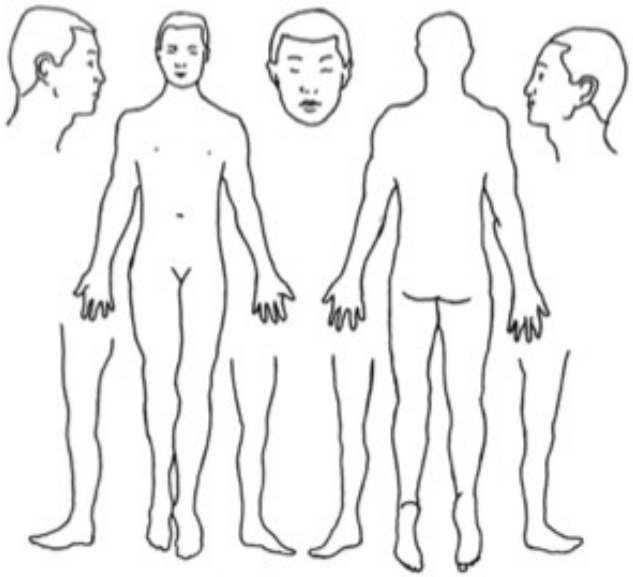
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills

☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Change in appetite ☐ Cravings

☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain

☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)

☐ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema

☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles

☐ Loss of hair ☐ Purpura ☐ Change in hair or skin texture ☐ Other _____

Musculoskeletal

☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in muscles ☐ Tremors

☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature ☐ Back pain

☐ Hernia ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness

☐ Neck pain ☐ Shoulder pain ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain

☐ Joint sprain ☐ Other _____

Head, eyes, ears, nose, and throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens ☐ Eye strain

☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Sore throat

☐ Spots in front of eyes ☐ Sinus problems ☐ Nose bleeding ☐ Grinding teeth ☐ Teeth problems

☐ Facial pain ☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting

☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other _____

Respiratory

☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing ☐ Bronchitis

☐ Pneumonia ☐ Chest pain ☐ Production of phlegm (what color) _____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath

☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites

☐ Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture _____

Neuro-psychological

☐ Loss of balance ☐ Lack of coordination ☐ Concussion ☐ Depression ☐ Anxiety

☐ Stress ☐ Bad temper ☐ Bi-polar

Genital-urinary

☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate ☐ Kidney stones

☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD ☐ Other _____

Female

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Fibroids

☐ Vaginal/genital discharge ☐ Ovarian cysts ☐ Irregular periods ☐ Clots

☐ Pain/cramps prior to/during periods ☐ Breast tenderness ☐ Breast lumps ☐ Hot flashes

☐ Moodiness related to periods ☐ Fertility problems

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-sections _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____ days, cycle _____ days

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male

☐ Prostate problems ☐ Fertility problems ☐ Erectile dysfunction ☐ Ejaculation problems ☐ Discharge

☐ Frequent seminal emission ☐ Painful/swollen testicles ☐ Other _____

I have completed this form correctly to the best of my knowledge.

Signature: _____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Are there any other health issues you want to discuss with us?

Signature Date