

## Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance: \_\_\_\_\_ (dd/mm/yr)

Date of Birth: \_\_\_\_\_  male  female

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital status

S  M  W  D  SEP

Phone #: home: \_\_\_\_\_ work: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### Check and indicate the age when you had any of the following:

#### General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

#### Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

#### Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

#### Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

#### Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

#### Genitourinary

- Bed-wetting
  - Bladder infection
  - Blood in urine
  - Kidney infection
  - Kidney stones
  - Prostate trouble
  - Pus in urine
  - Stress incontinence
- Urination
- Overnight more than twice
  - More than 8x in 24hrs
  - Decreased flow/force
  - Painful urination
  - Urgency to urinate

#### Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

#### Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

#### Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

#### Menstrual flow

Reg.  Irreg.  Pain / cramps

Days of flow: \_\_\_\_ Length of cycle: \_\_\_\_

Date - 1<sup>st</sup> day last period: \_\_\_\_\_

Are you pregnant?  yes,  no

If yes, how many months? \_\_\_\_

How many children do you have? \_\_\_\_

Birth control method: \_\_\_\_\_

Date of last PAP test: \_\_\_\_\_

normal,  abnormal

Date of last mammogram: \_\_\_\_\_

normal,  abnormal

#### Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

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**Patient Intake Form** (side 2)

Give a brief detailed description of the problem you are currently experiencing: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

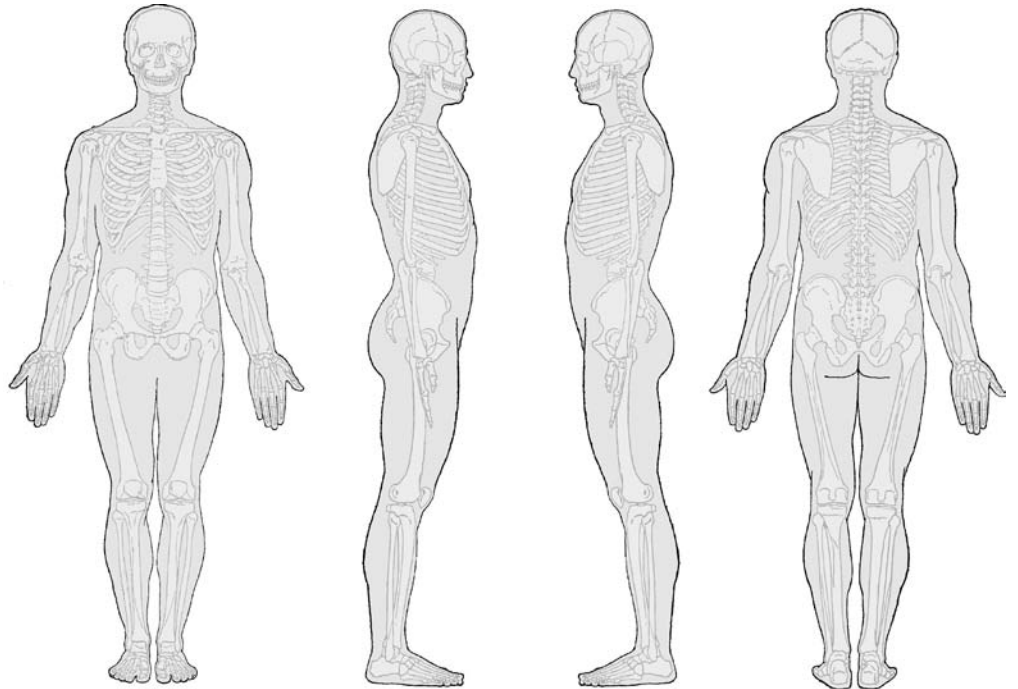
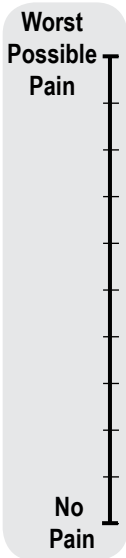
How long have you had this condition? \_\_\_\_\_ Is it getting worse?  yes,  no \_\_\_\_\_

Does it bother you (check appropriate box):  work,  sleep,  other: \_\_\_\_\_

What seemed to be the initial cause: \_\_\_\_\_

**Please mark you area(s) of pain on the figure below**

**Please place a mark at the level of your pain on the scale below:**



**Past health history**

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family history**

**If any blood relative has had any of the following conditions, please check and indicate which relative(s)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple sclerosis  |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Bleed easily     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease     |

**Do you have any other health issues or concerns that our staff should be made aware of?** \_\_\_\_\_