

Patient Intake

Patient Information

Date: _____
Last Name: _____
First Name: _____
Middle Initial: _____
Address: _____
City: _____ State: _____ Zip: _____
Sex: M ___ F ___ Age: _____
Birth date: _____
Marital Status: M ___ S ___ W ___ D ___
Occupation: _____
Employer: _____
Spouse's Name: _____

Contact Information

Home Phone: _____
Cell Phone: _____
Best Time to reach you: _____
Emergency Contact: _____
Phone Number: _____
Relationship: _____
E-mail: _____

Would you like us to text and/or email you appointment reminders?

Text: Y ___ N ___

Cell phone carrier: _____

Email: Y ___ N ___

*You will only receive text/email regarding appointments.

PATIENT CONDITION

Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Y ___ N ___ Don't know _____

Rate the severity of your condition on a scale from 1 (least problematic) 10 (most problematic) _____

If you are experiencing pain, indicate the type of pain:

Sharp Dull Throbbing Numbness Aching

Shooting Burning Tingling Cramping Swelling

Other: _____

HEALTH HISTORY

What treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractic
 None Other _____

Name of doctor(s) that have treated your condition _____

Place an X on Yes or No if you have had any of the following:

AIDS/HIV Yes No	Diabetes Yes No	Migraine Headache Yes No	Rheumatic Fever Yes No
Alcoholism Yes No	Emphysema Yes No	Miscarriage Yes No	Scarlet Fever Yes No
Allergy Shot Yes No	Epilepsy Yes No	Mono Yes No	Stroke Yes No
Anemia Yes No	Fractures Yes No	Mult. Sclerosis Yes No	Suicide Attempt Yes No
Anorexia Yes No	Glaucoma Yes No	Mumps Yes No	Thyroid Problem Yes No
Appendicitis Yes No	Goiter Yes No	Osteoporosis Yes No	Tonsillitis Yes No
Arthritis Yes No	Gonorrhea Yes No	Pacemaker Yes No	TB Yes No
Asthma Yes No	Gout Yes No	Parkinson's Yes No	Tumors Yes No
Bleeding Disorders Yes No	Heart Disease Yes No	Hepatitis Yes No	Typhoid Fever Yes No
Breast Lump Yes No	Hernia Yes No	Pinched Nerve Yes No	Ulcers Yes No
Bronchitis Yes No	Herniated Disc Yes No	Pneumonia Yes No	Vaginal Infection Yes No
Bulimia Yes No	Herpes Yes No	Polio Yes No	Venereal Disease Yes No
Cancer Yes No	High Cholesterol Yes No	Prostate Problem Yes No	Whooping cough Yes No
Cataracts Yes No	Kidney disease Yes No	Prosthesis Yes No	Other _____
Chemical Dependency Yes No	Liver Disease Yes No	Psychiatric Care Yes No	
Chicken Pox Yes No	Measles Yes No	Rheumatoid Arthritis Yes No	

Exercise	Work Activity	Habits	
None	Sitting	Smoking	Packs/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Daily	Light Labor	Coffee/Caffeine	Cups/Day _____
Heavy	Heavy Labor	High Stress	Reason _____

Are you pregnant: Y ___ N ___ Due date: _____

Medications: _____

Allergies: _____

Vitamins/Herbs/Minerals: _____
