Patient Intake Form

Patient's Name: _____

Age:_____ Date of Birth:_____

Gender: M / F

Name of Patient's Gaurdian (if applicable):_____

Address: _____

Preferred Contact: (choose one)

Phone:_____ E-mail:_____

Marital Status:

□ Single □ Married □ Living w/ Significant Other
□ Divorced/Separated □ Widowed □ Other: _____

What is the *main* reason for today's visit? _____

Please list up to five other complaints/symptoms you are experiencing in order from most to least troubling:

1. _____ 2. _____

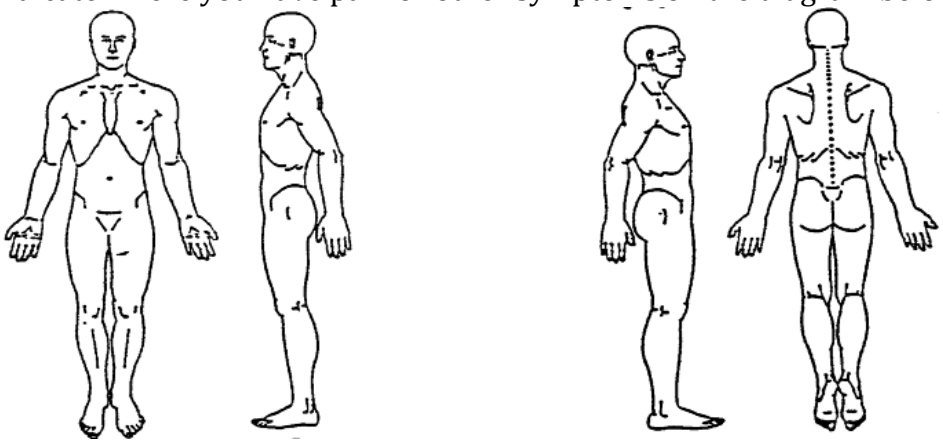
3. _____ 4. _____ 5. _____

How long have you had your *main* complaint? _____

How did it happen? _____

What would you like your treatment to accomplish (Goals)?_____

Please indicate where you have pain or other symptoms on the diagram below:



Patient/Gaurdian Signature:_____Date:_____

Do you/have you had any of the following?: (please circle, explain if "YES")

Dependency on illegal/addictive substances?
No / Yes; please explain:_____

Significant *HEAD* complaints such as headache, dizziness, head trauma, fainting, etc?
No / Yes; please explain:_____

Significant *EYE* complaints such as spots/flashes/changes in vision, sensitivity to light, double vision, etc.?
No / Yes; please explain:_____

Significant *EAR* complaints such as ringing, infection, hearing loss, drainage, etc.?
No / Yes; please explain:_____

Significant *NOSE* complaints such as nosebleeds, sinus problems, dripping etc.?
No / Yes; please explain:_____

Significant *MOUTH* complaints such as jaw pain, trouble swallowing, bleeding gums, changes is taste, hoarseness, etc.?
No / Yes; please explain:_____

Significant *LUNG* complaints such as asthma, pneumonia, wheezing, persistent cough, difficulty breathing, etc?
No / Yes; please explain:_____

Significant *CARDIO VASCULAR* complaints such as chest pain, palpitations, ankle swelling, cold/hot feet or hands, leg/calf cramps, high/low blood pressure, etc?
No / Yes; please explain:_____

Significant *GASROINTESTINAL* complaints such as bloating, gas, nausea/vomiting, ulcers, diarrhea/constipation, blood in stool, liver disease, gall bladder disease, etc?
No / Yes; please explain:_____

Significant *GENITOURINARY* complaints such as difficulty/pain urinating, blood in urine, increase/decrease in urination, genital infection, kidney stones, etc.?
No / Yes; please explain:_____

Significant *SKIN* complaints such as rashes, excessive bruising, hair loss, changes in moles, itching/peeling, etc.?
No / Yes; please explain:_____

Significant *NEUROLOGIC* complaints such as seizures/epilepsy, strokes, tingling/numbness, weakness, poor coordination, etc.?
No / Yes; please explain:_____

Significant *MUSCLE/BONE* complaints such as osteoporosis, arthritis, bone pain, dislocations, etc.?

No / Yes; please explain:_____

Significant *PSYCHOLOGICAL* complaints such as excessive stress, depression, anxiety, mood swings etc.?

No / Yes; please explain:_____

Please list any significant traumas or injuries you've had and when:_____

_____

Please list any previous hospitalizations and/or surgeries and when:_____

_____

Please list any current medications/vitamins/supplements you are taking: _____

_____

Please list any allergies you have:_____

_____

How often do you use alcohol?: □Never □Seldom □Monthly □Weekly □Daily

How often do you use caffeine?: □Never □Seldom □Monthly □Weekly □Daily

Smoking status: □ Never smoked □ Currently smoke □ Quit _____ years ago

Do you currently feel safe at home? Yes / No

Females: Have you had your first menstruation? Yes / No

Do you have a *FAMILY HISTORY* (immediate family) of:
Cancer? No / Yes; _____
Heart Disease? No / Yes; _____
Stroke? No / Yes;_____
High Blood Pressure?_____
Depression: No / Yes; _____
Other: _____

How much water do you drink each day? About _____ cups / oz.

What type of physical activity do you do?_____

_____

How often?_____

Are you currently under the care of another physician?

No / Yes; who?:_____

Patient/Gaurdian Signature:_____Date:_____