

Date: _____

Patient Intake Form

First Name: _____ Middle Initial: _____ Last Name: _____

What do you prefer to be called? _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Ok to leave messages on: Home Cell Work

Sex: Male Female | Marital Status: Single Married Widowed Divorced Unknown Minor

Date of Birth: _____ Social Security Number: _____

Employer: _____ Job Description: _____

How did you hear about the doctor: _____

Spouse/Significant Other: _____ Date of Birth: _____

Emergency Contact Name and Number: _____

Responsible Party:

Name of person responsible for this account: _____

Relationship to patient: _____ DOB: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Please briefly describe your chief complaint: _____

When did you first notice the symptoms? _____

What are these symptoms preventing you from doing? _____

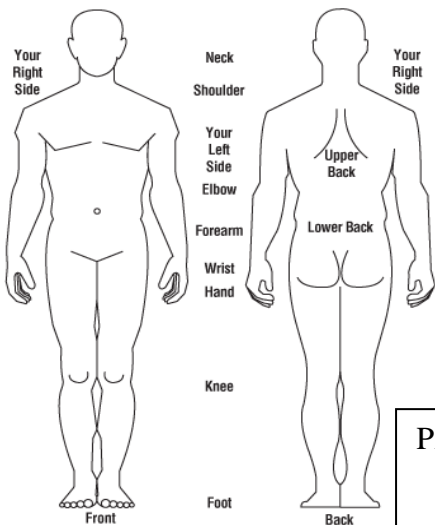
Do your symptoms interfere with: Work Sleep Walking Sitting Bending Lifting

If you are experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant

Since the problem started, it is: About the Same Getting Better Getting Worse

What makes it worse? And better, if anything? _____

Other Doctors seen for this problem (please list): _____



Place an "X" on the drawing to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

- A- Ache
- B- Burning
- N- Numbness
- T- Throbbing
- ST- Stabbing
- SP- Spasm
- P- Pins and Needles

PAIN SCALE: Please circle the number that best describes your overall pain:											
0	1	2	3	4	5	6	7	8	9	10	10+
NONE			LITTLE			MEDIUM			SEVERE		

ACTIVITIES OF DAILY LIVING

Please circle the number to select the most appropriate statement. 0 = Able to function / 10 = Unable to function

Family/Home Responsibilities (chores, duties around the house): 0 1 2 3 4 5 6 7 8 9 10

Recreation/Social Activity (hobbies, sports, social functions): 0 1 2 3 4 5 6 7 8 9 10

Occupation (activities directly related to one's job): 0 1 2 3 4 5 6 7 8 9 10

Self Care (personal maintenance and independent daily living): 0 1 2 3 4 5 6 7 8 9 10

YOUR HEALTH PROFILE

Do you drink water daily? Y N How much: _____

Do you drink caffeine? Y N How much: _____

Do/did you smoke? Y N How much: _____

Do/did you drink alcohol? Y N How much: _____

Do you take any supplements? Y N What kind/which: _____

Do/did you play any adult sports? Y N Which: _____

Do you exercise regularly? Y N Type: _____

How old is your mattress? ___yrs. How many pillows do you sleep with? ___

Do you sleep on your back / front / side (circle all that apply)

Women: Are you pregnant? Yes No Taking Birth Control Pills? Yes No

PAST HISTORY

Have you had any illnesses in the past? _____

Have you had any injuries in the past? _____

Have you been hospitalized? _____

Have you had ANY surgeries? _____

Have you been in an auto accident? _____

List any medications you are taking: _____

CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pleurisy | |
| <input type="checkbox"/> Eating Disorders | | | |

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Muscles & Joints

- Low Back Pain
- Pain Between Shoulder Blades
- Neck Pain/Stiffness
- Arm/Elbow/Wrist Pain
- Walking Problems
- Difficulty Chewing
- Clicking Jaw
- Leg/Knee/Foot Pain
- Hip Pain
- Pain in Tailbone

Eye, Ear, Nose & Throat

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose
- Ringing in Ears
- Nose Bleeds
- Sinus Trouble
- Swollen Glands
- Frequent Colds

General Problems

- Fatigue
- Night Sweats
- Loss of Sleep
- Fever
- Headaches
- Weakness
- Migraines

Heart & Lungs

- Wheezing/Bronchitis
- Chest Pain
- Asthma
- Shortness of Breath
- High Blood Pressure
- Low Blood Pressure
- Irregular Heart Beat
- Heart Surgery
- Lung Congestion
- Coughing
- Spitting Blood
- Varicose Veins
- Ankle Swelling

Stomach/Intestines

- Poor Appetite
- Excessive Appetite
- Excessive Thirst
- Nausea
- Vomiting
- Poor Digestion
- Hemorrhoids/Piles
- Liver Trouble
- Gall Bladder
- Weight Trouble
- Stomach Cramps
- Stomach Pain
- Gas/Bloating
- Heartburn
- Black/Bloody Stool
- Colitis
- Diarrhea
- Constipation

Kidney/Bladder

- Painful Urination
- Excessive Urine
- Discolored Urine
- Bedwetting
- Bad Urine Control

Nervous System

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Confusion
- Depression
- Fainting
- Convulsions/Seizures
- Cold Extremities

Women

- Menses Irregular
- Menstrual Cramps
- Vaginal Pain
- Breast Lumps
- Pain During Sex
- Infertility
- Miscarriage

Men

- Prostate Pain
- Impotence
- Infertility

Bending:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Care-Infirm Family:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Carrying Groceries:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Change Position:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Climb Stairs:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Driving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Ext. Computer Use:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Feeding:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Household Chores:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Kneeling:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Lift Children:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Lifting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Pet Care:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Reading:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Self Care:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Self Care - Bathing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Self Care -Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Self Care - Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Sexual Activities:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Sleep:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Static Sitting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Static Standing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Walking:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform
Yard Work:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev-Unable to Perform

The statements made on this form are accurate to the best of my knowledge.

Signature

Date