Confidential Patient Intake Form

Date_____

Name _____
Address _____

_____

Birthdate _____ Phone# _____
Single ____ Married ____ Divorced ____ Partner ____
Children _____ Pregnant? _____
Occupation _____
How did you hear about us? _____

Medical Conditions (check and describe below):

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Blood clots
- ☐ Blood pressure
- ☐ Cancer
- ☐ Cholesterol high
- ☐ Diabetes
- ☐ Digestive issues
- ☐ Emotional issues
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Gynecological
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Infection
- ☐ Kidney disorder
- ☐ Liver disorder
- ☐ Lung disorder
- ☐ Migraines
- ☐ Neuropathy
- ☐ Neuropathy
- ☐ Sinusitis
- ☐ Thyroid disorder

_____
_____
_____

Surgeries/Medical procedures (list & date)

_____
_____
_____
_____

Car accidents (list & date) _____

_____
_____
_____

Other traumas (list & date)_____

_____
_____

Main Complaint (pain & other symptoms) _____

_____
_____

When did it begin? _____
What event caused it? _____

_____
_____
_____

What makes it feel better? _____
What makes it feel worse? _____
Other doctors/treatments _____

_____

Typical pain level varies from ____ to ____ over 10
(on a scale from 0 to 10, 10 is worst pain possible)
Pain is worse:
Morning _____ Evening _____
Sitting _____ Standing _____
During activity _____ After activity _____
Sleep problems? _____
Sleep position _____
Prescription medicines: _____

_____
_____

Vitamins/herbs: _____

_____
_____
_____

Exercise _____

_____

Other hobbies/activities _____

_____

Goal of treatment (what do you want to do that you are unable to do because of your symptoms?)

_____
_____
_____

Is there anything else we should know about?

_____
_____

Diet:

Typical breakfast _____

_____

_____

Typical lunch _____

_____

_____

Typical dinner _____

_____

_____

Restrictions _____

_____

Cravings _____

Coffee/tea (how many cups per day?) _____

Sodas (how many per day?) _____

Smoke (how many packs per day?) _____

Alcohol (how many drinks per week?) _____

Water (how many glasses per day?) _____

Doctor's comments _____

_____

_____

_____

_____

_____

_____

Please shade in any areas of pain or other symptoms below:

RIGHT

LEFT

Left Right Right Left