PATIENT INFORMATION

NAME_____DATE_____
ADDRESS_____CITY_____ZIP_____

E-MAIL_____HOME PHONE_____CELL PHONE_____
AGE_____DATE OF BIRTH_____SEX_____
SOCIAL SECURITY#_____
SINGLE,WIDOWED,MARRIED,SEPARATED,DIVORCED_____

NEAREST RELATIVE NOT LIVING WITH YOU_____PHONE_____
NEAREST FRIEND NOT LIVING WITH YOU_____PHONE_____
SPOUSE NAME_____
SPOUSE PHONE_____

EMPLOYER_____
PHONE_____
ADDRESS_____CITY_____ZIP_____

PRIMARY CARE PHYSICIAN_____
PHONE_____
WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____PHONE_____

INSURANCE COMPANY RESPONSIBLE FOR THE BILL_____
PHONE_____CLAIM #_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and completed above answers. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in my status or the above information.

***Signature_____ Date _____**

***Parent (if minor)_____Date _____**

Main Complaints:

1._____Duration:_____Radiation:_____

Relieves:_____Aggravates:_____Description:_____

2._____Duration:_____Radiation:_____

Relieves:_____Aggravates:_____Description:_____

3._____Duration:_____Radiation:_____

Relieves:_____Aggravates:_____Description:_____

4._____Duration:_____Radiation:_____

Relieves:_____Aggravates:_____Description:_____

Morning:Better/Worse_____Night:Better/Worse_____
_____

Past Diagnosis:_____
_____

Medications taken today:
_____
_____
_____

For Office Use Only

Date:_____

Acct #:_____

Patient Height _____

Patient Weight
_____

Patient BMI _____

Patient Blood Pressure _____

PATIENT INTAKE FORM

Name: ___________________________________

Race (circle only 1)

American Indian
Asian
Black or African American
Native Hawaiian
Alaska Native
White
Pacific Islander
Other
Declined to State

Ethnicity (circle only 1)

Declined to State
Not Hispanic or Latino
Hispanic or Latino

Preferred Language ____

***Are your present problems due to injury? ☐Yes ☐No** *Enter the date of the injury______________________

***Was the injury? ☐Job Related ☐Auto Accident ☐Personal Injury ☐Other:**
____

***Has the accident been reported? ☐Yes ☐No** *Name of the driver:
____

Briefly describe the accident, injury or illness:____
____
____
____

List symptoms experienced immediately after the injury; Choose the severity level associated with each symptom

___________________________☐(1)Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐ (7)☐ (8) ☐(9) ☐(10)Remarkably severe

___________________________☐(1)Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐ (7)☐ (8) ☐(9) ☐(10)Remarkably severe

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___________________________☐(1)Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐ (7)☐ (8) ☐(9) ☐(10)Remarkably severe

List any tests, studies or medications received for this condition

☐Test/Studies: ____

☐Medications:
____

Were you admitted to the hospital due to this condition: ☐ Yes ☐ No

If yes, what hospital?__________________Transported by? ☐ Ambulance ☐Police ☐Other:________________

Date Admitted:________________Date Released:________________Length of stay: _______________________

List the hospital procedures received: ____

Do you have any current work restrictions due to this condition?

Off Work: ☐ **Yes** ☐ **No** ☐**Previously** From: _____ To: _____

Light Duty: ☐ **Yes** ☐ **No** ☐**Previously** (If yes, what are/were your restrictions?)

_____

What type of work do you do?_____

Do you suffer from any condition other than that for which you are now consulting us? ☐ **Yes** ☐ **No**

_____

List any past conditions you may have had:

_____

HABITS

☐ Current Everyday Smoker ☐ Current Some Per Day Smoker

☐ Former Smoker ☐ Never Smoker

☐ Drinking Alcohol: (Amount/Day): _____ ☐ Coffee Cups/Day: _____

☐ Soft Drink Bottle or Cans/Day: _____ ☐ Water Cups/Day: _____

EXERCISE

☐ None

☐ Moderate

☐ Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐

Are you taking any medication (prescription or over-the-counter)? ☐ **Yes** ☐ **No**

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral or Intravenous Route: Oral or Intravenous

Other:_____ Other:_____

Frequency: _____ Frequency:_____

Began Use:_____ Began Use:_____

Discontinued Use:_____ Discontinued Use: _____

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral or Intravenous Route: Oral or Intravenous

Other:_____ Other:_____

Frequency: _____ Frequency:_____

Began Use:_____ Began Use:_____

Discontinued Use:_____ Discontinued Use: _____

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral or Intravenous Route: Oral or Intravenous

Other:_____ Other:_____

Frequency: _____ Frequency:_____

Began Use:_____ Began Use:_____
Discontinued Use:_____ Discontinued Use: _____

Have you taken any medications in the recent past? ☐ **Yes** ☐ **No** If yes, which ones?:_____

Do you have allergies to medication? ☐ **Yes** ☐ **No**
If Yes, please indicate the following:
Allergy:_____ Allergy:_____
Reaction:_____ Reaction:_____
Start Date:_____ Start Date:_____
End Date:_____ End Date:_____

Do you have allergies to medication? ☐ **Yes** ☐ **No**
If Yes, please indicate the following:
Allergy:_____ Allergy:_____
Reaction:_____ Reaction:_____
Start Date:_____ Start Date:_____
End Date:_____ End Date:_____

Have you ever had any surgeries? ☐ **Yes** ☐ **No** (if yes, please enter the approximate date of surgery.)

DATE	**DATE**	**DATE**
_____Back Operation	_____Hernia	_____Gall Bladder
_____Female Organs	_____Thyroid	_____Stomach

Other_____

Have you ever had X-Rays taken? ☐ **Yes** ☐ **No** When?_____By Whom?_____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ☐ Allergies (What)_____ _____
- ☐ Bronchitis
- ☐ Chills (constant)
- ☐ Convulsions
- Spitting Phlegm
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Numbness or Pain
- In arms/legs/hands

GASTRO INTESTINAL

- ☐ Belching or Gas
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Heartburn
- ☐ Bloody Stools
- ☐ Acid Reflux
- ☐ Irritable Bowel

EYES/EARS NOSE/THROAT

- ☐ Asthma
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear Noises ☐
- ☐ Thyroid Problems
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Pain in Eyes
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Sinusitis
- ☐ Sore Throats
- ☐ Tonsillitis

RESPIRATORY

- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficult Breathing
- ☐ Spitting Blood

GENITOURINARY

- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Prostate Trouble
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Inability to control Urine