

# Patient Intake Form

Date \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

DOB \_\_\_\_\_

Sex  Male  Female

SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone 1 \_\_\_\_\_  
 Home  Mobile  Work  Other

Phone 2 \_\_\_\_\_  
 Home  Mobile  Work  Other

Fax \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Employer Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Job Status  
 Not Employed  Employed  
 Part-Time Student  Retired  
 Full-Time Student

Marital Status  
 Single  Married  Other

Receive Appointment Reminders  
 Declined  Voice  Text  Email

Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs

**Reason For Visit:**  New Patient  Adjustment  Physical  Consultation  X-Rays  Therapy  Injury  
 Report of Findings  Auto Accident  Re-Examination  Other \_\_\_\_\_

**Referred By:**  Provider  Friend  Family  Other \_\_\_\_\_  
Referred By Name \_\_\_\_\_

**How Heard of Us:**  Walk in  Referral  Phone Book  Website  
 Advertisement  Other \_\_\_\_\_

## Demographics

**Race:**  White  Black or African American  American Indian or Alaska Native  Asian  
 Native Hawaiian or Other Specific Islander  Other \_\_\_\_\_

**Ethnicity:**  Hispanic or Latino  Non-Hispanic or Latino  Unknown  Other \_\_\_\_\_

**Dominance:**  Right  Left  Ambidextrous

## Insurance Information

### Primary Insurance:

Insured First Name \_\_\_\_\_

Insured Last Name \_\_\_\_\_

DOB \_\_\_\_\_

Insurance Name \_\_\_\_\_

Insurance Phone \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_

Visit Copay \_\_\_\_\_

Co-Ins % \_\_\_\_\_

Deductible \_\_\_\_\_ Applied \_\_\_\_\_

\$/Year \_\_\_\_\_ Visits/Year \_\_\_\_\_ Therapy Visits/Year \_\_\_\_\_

PCP Referral Required  Yes  No

Policy Effective Date \_\_\_\_\_

Cal Yr / Other \_\_\_\_\_

Other \_\_\_\_\_

**Secondary Insurance:**

Insured First Name \_\_\_\_\_

Insured Last Name \_\_\_\_\_

DOB \_\_\_\_\_

Insurance Name \_\_\_\_\_

Insurance Phone \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to Insured  Self  Spouse  Child  Other

Visit Copay \_\_\_\_\_

Co-Ins % \_\_\_\_\_

Deductible \_\_\_\_\_ Applied \_\_\_\_\_

\$/Year \_\_\_\_\_ Visits/Year \_\_\_\_\_ Therapy Visits/Year \_\_\_\_\_

PCP Referral Required  Yes  No

Policy Effective Date \_\_\_\_\_

Cal Yr / Other \_\_\_\_\_

Other \_\_\_\_\_

**Emergency Contact Information**

First Name \_\_\_\_\_

Relationship \_\_\_\_\_

Last Name \_\_\_\_\_

Phone 1 \_\_\_\_\_

Phone 2 \_\_\_\_\_

**Health History**

**Medications/Vitamins/Supplements:**


**Allergies:**


**Illnesses:** Please check all that apply

- AIDS/HIV
- Anemia
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Cancer
- Chemical Dependency
- Chicken Pox
- Other \_\_\_\_\_
- Chronic Fatigue
- Depression
- Diabetes
- Emphysema
- Epilepsy
- Fibromyalgia
- Fractures
- Gallstones
- Glaucoma
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herniated Disc
- High Blood Pressure
- High Cholesterol
- Immune Deficiency
- Kidney Disease
- Liver Disease
- Migraine Headaches
- Miscarriage
- Multiple Sclerosis
- Osteoporosis
- Pacemaker
- Parkinson's Disease
- Pinched Nerve
- Prostate Problems
- Prosthesis
- Psychiatric Disorder
- Rheumatoid Arthritis
- Seizures
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Tumors/Growths
- Ulcers
- Vaginal Infections
- Venereal Disease
- Whooping Cough

Is there any history in your family for any of the above conditions?

Who? \_\_\_\_\_

What did they have? \_\_\_\_\_

**Surgeries:**


**Traumas:**


**Complaints:** (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

**Does the pain travel anywhere else?** \_\_\_\_\_

**Do you know what caused the problem?** \_\_\_\_\_

**Do you notice the pain during a certain time of day?** \_\_\_\_\_

**Frequency:**  Intermittent  Occasional  Frequent  Constant  
\_\_\_\_\_ times per  Day  Week  Month  Year

**Duration:** Lasting \_\_\_\_\_  Minutes  Hours

**Onset:** Have had symptoms over the past \_\_\_\_\_  Days  Weeks  Months  Years

**Intensity:**  Minimal  Slight  Moderate  Severe

**Is your condition:**  Same  Better  Worse

**Rate your pain:**  0  1  2  3  4  5  6  7  8  9  10  
*0 being no pain at all and 10 being the worst pain imaginable*

**Quality: Describe your pain:**  aching  burning  cramping  deep  dull  numb  radiating  sharp  
 shooting  sore  stabbing  stiff  swelling  tight  tingling  throbbing

**Aggravating Factors: What makes the problem worse?**  nothing  most movements  bending  carrying things  
 coughing  driving  eating  exercise  going down stairs  going from lying to sitting  
 going from lying to standing  going from sitting to standing  heat  housework  ice  jogging  lifting  
 lying down  massage  pulling  pushing  running  sitting  sleeping  sneezing  squatting  
 standing  standing for a long period of time  stress  stretching  taking a deep breath  turning  
 twisting  walking  working

**Relieving Factors: What makes the problem better?**  nothing  anti-inflammatories  bracing  chiropractic care  
 elevation  exercise  heat  ice  massage  movement  pain killers  rest  stretching  
 walking  wraps

**What daily activities are affected due to the problem?**  bathing  caring for children  cleaning  climbing stairs  
 cooking  doing laundry  dressing  driving  eating  exercising  going from laying down to sitting  
 going from sitting to standing  grooming  house work  laying down  lifting  oral care  sex  
 shopping  sitting  sleeping  social/recreational activities  standing  stretching  toileting  
 transferring  using technology  using phone  walking  watching tv  working  yard work

**Have you been given a diagnosis for this problem? If so, what was the diagnosis?** \_\_\_\_\_

**What treatment(s) have you tried for your condition?**  None  Medication  Surgery  Physical Therapy  
 Chiropractic  Other \_\_\_\_\_

**Are you presently under the care of a physical and/or mental health care provider?** If so, by whom? \_\_\_\_\_

If so, what conditions? \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_ By whom? \_\_\_\_\_

**Energy Level:**  Good  Insufficient  Erratic  
 Low (Time of Day) \_\_\_\_\_  High (Time of Day) \_\_\_\_\_

**Sleep:**  Trouble falling asleep  Trouble staying asleep  Restful  Other \_\_\_\_\_

**Stress:**  None  Low  Moderate  Severe What causes stress? \_\_\_\_\_

**Have you had unexpected weight loss in the last 6 months?**  Yes  No If yes, how much? \_\_\_\_\_

## Daily Habits

**Do you smoke?**  Never smoked  Unknown if ever smoked  Unknown if currently smokes

Current every day smoker  Current some day smoker  Former smoker

If yes, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Daily Caffeinated Beverages:**  Unknown  None  1 to 3  4 to 6  7 to 10  11 to 15  16 to 20  21 to 25  Over 25

**Weekly Alcoholic Drinks:**  Unknown  None  1 to 3  4 to 6  7 to 10  11 to 15  16 to 20  21 to 25  Over 25

**Do you exercise regularly?**  no  light  moderate  heavy

## Review of Systems

**Musculoskeletal:** Please check all that apply  None

Arm/hand pain  back pain  Feet/leg pain  hip  Knee  Lower back pain  Mid back pain  Muscle or joint pain  
 Neck pain  Redness of joints  Shoulder(s) pain  Stiffness  Swelling of joints  Upper back pain

**Cardiovascular/Respiratory:** Please check all that apply  None

Chest pain, pressure or discomfort  Cold hands/feet  Coughing up blood (hemoptysis)  Coughing up phlegm  
 Difficulty breathing  Dizziness/lightheaded  Fainting  Irregular heartbeat  Palpitations  Persistent Coughing  
 Shortness of breath  Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)  
 Swelling (edema)  Tightness in chest  Wheezing  Other \_\_\_\_\_

**Head/Neck:** Please check all that apply  None

Dizziness  Facial pain  Grinding Teeth  Headache  Head injury  Hoarseness  Jaw Clicks  Lumps  
 Migraines  Pain  Sore throat  Stiffness  Swollen Glands  Tooth problems  Trouble swallowing  
 Other \_\_\_\_\_

**Eyes:** Please check all that apply  None

Blurred Vision  Burning  Cataracts  Double vision  Dryness  Flashing lights  Glasses/Contacts  Glaucoma  
 Itching  Pain  Redness  Specks  Vision Problems  Other \_\_\_\_\_

**Ears:** Please check all that apply  None

Buzzing in ears  Decreased hearing  Drainage  Earache  Ear infections  Poor balance  Poor hearing  
 Ringing in ears (tinnitus)  Other \_\_\_\_\_

**Nose:** Please check all that apply  None

- Allergies  Blocked Sinuses  Discharge  Excessive mucus  Hay fever  Itching  Nose bleeds  
 Sinus pressure/pain  Stuffiness/blockage  Other \_\_\_\_\_

**Throat/Mouth:** Please check all that apply  None

- Bleeding  Blue lips  Braces  Dentures  Difficulty swallowing  Dry mouth  Hoarseness  
 Mouth pain  Non healing sores  Redness  Sore throat  Sores on lips or tongue  Swelling  
 Thrush  Tooth pain  Other \_\_\_\_\_

**Urinary:** Please check all that apply  None

- Blood in urine (hematuria)  Burning or pain  Difficulty urinating  Frequent urinary tract infections  
 Frequent urination  Incontinence  Kidney infections  Kidney stones  Unable to hold urine (incontinence)  
 Up at night to urinate  Urgency  Water retention  Other \_\_\_\_\_

**Gastrointestinal:** Please check all that apply  None

- Change in appetite  Change in bowel habits  Constipation  Diarrhea  Heartburn  Nausea  
 Rectal bleeding  Swallowing difficulties  Yellow eyes or skin (jaundice)  Other \_\_\_\_\_

**Endocrine:** Please check all that apply  None

- Change in appetite  Cold intolerance  Constipation  Diarrhea  Dry skin  Excessive thirst  
 Frequent urination  Heat intolerance  Sweating

**Vascular/Hematologic:** Please check all that apply  None

- Calf pain with walking (claudication)  Cold hands and feet  Ease of bleeding  Ease of bruising  Leg cramping

**Neurologic:** Please check all that apply  None

- Dizziness  Easily angered/irritated  Fainting  Frequent crying  Memory confusion  Nervousness  Neuralgia  
 Numbness  Poor concentration  Seizures  Suicidal thoughts  Tingling  Tremors  Weakness  
 Worry/anxiety  Other \_\_\_\_\_

**Psychiatric:** Please check all that apply  None

- Anxiety  Depression  Memory loss  Nervousness  Stress  Other \_\_\_\_\_

**Female:**

- Are you pregnant?  Yes  No Date of last period \_\_\_\_\_ Number of days between periods \_\_\_\_\_  
Age started \_\_\_\_\_ Age stopped \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_ Number of miscarriages \_\_\_\_\_  
Number of abortions \_\_\_\_\_ Number of Cesareans \_\_\_\_\_ Operations  Cervix  Uterus  Ovaries

Please check all that apply  None

- Clotting  Dark color  Discharge  Food cravings  Heavy bleeding  Hot flashes  Infections  
 Irregular periods  Itching or rash  Leg cramps  Light bleeding  Little/no sex drive  Menstrual pain/cramps  
 Missed periods  Mood swings  Painful breasts  Pain with sex  STD's  Vaginal discharge  
 Vaginal dryness  Vaginal sores  Water retention  Other \_\_\_\_\_

**Male:** Please check all that apply  None

- Discharges  Erectile dysfunction  Hernia  Impotence  Low sex drive  Masses or pain  Painful urination  
 Pain with sex  Painful discharge  Prostate problems  Sores  STD's  Other \_\_\_\_\_

## Family History

**Family Member Name**      **Relationship**      **Status**      **Conditions**

Family Member Name	Relationship	Status	Conditions

## Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

## Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative      Date \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient, Parent, Guardian or Personal Representative      Date \_\_\_\_\_