Patient Intake Form

Name: _____ Date of Birth: _____

Today's Date: _____ Home Phone: (_____) ____ - _____

Cell Phone: (____) - _____-_____ Email Address: _____

Best way to contact (Circle): Home Cell Gender (Circle): Male/Female

Home Address: _____

Emergency Contact: _____

Emergency Contact Phone Number: (____) - _____ - _____

Relationship to Patient: _____ Referring Physician: _____

Primary Care Physician: _____

Employer: _____ Employer Phone #: (____) _____-____

Employer Address: _____

Occupation: _____ Chief Complaint: _____

Insurance: _____ Insured's Name: _____

Insured's Date of Birth_____ Insured's Phone #: (____)-_____-____

Insured's Relationship to Patient: _____Insured's Employer: _____

Insured's Employer Address: _____

_____

Current Complaint(s):

Date of Injury or Onset of Symptoms: _____

How did you get injured: _____

Have you had an injury to this body part before, if yes when and what for? _____

_____

Have you had (Circle): X-Rays CT Scan MRI Other _____

Are you currently under another healthcare professional's care (i.e. Osteopath,

Dentist, Chiropractor, etc.): _____

If you are female, is there any possibility you are pregnant (Circle): Yes or No

What makes your pain better: _____

What makes your pain worse: _____

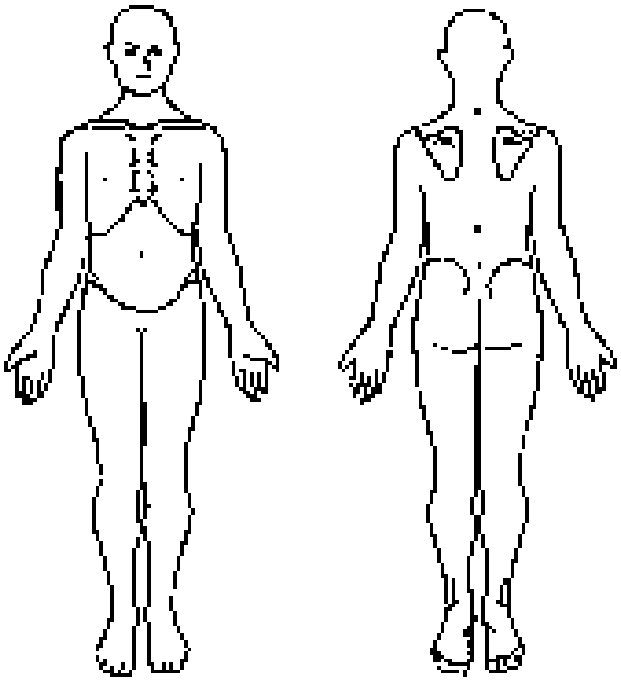
Prior Level of Function:

What were you able to do prior to this injury that you are not able to do presently? _____

What do you hope to achieve as a result of this treatment?_____

_____

Please indicate on the areas and type of pain with the following symbols on the body chart below:



SHARP
XXXX

DULL
OOOO

ACHING
****

NUMBNESS
NNNN

TINGLING
TTTT

BURNING
// // // //

Please rate your pain on the following pain scale: (Circle the number)

0 1 2 3 4 5 6 7 8 9 10
(none) (severe)

Is your pain constant or does it come and go? _____

Please circle which of the following activities you have difficulty with or are compensating for:

Dressing	Work Activities
Walking	Sitting
Hygiene (Bathing, toileting, grooming)	Sleeping
Skills with Dominant Hand	Standing
Household Activities	Other:

What recreational activities do you do on a regular basis (i.e. swimming, running, sports, weightlifting, etc)? _____

How many days a week are you physically active? _____

Do you have any family values or cultural beliefs that may affect our approach to treatment? _____

In the space below, please tell us anything else you think your therapist will need to know:

_____

_____

_____

_____

Signature of Patient: _____ Date: _____

Signature of Therapist: _____ Date: _____

Review of Medications

Your Name: _____

- I am not currently taking any medications, including prescription & non-prescription.

Signature: _____ Date: _____

- I am currently taking the following medications including prescription and non-prescription drugs:

Prescription Medications:

Example: Vicodin 2 500Mg 1x/day for pain

Name of Rx:	# of pills	Mg	x/day	Purpose

Over The Counter Medication (OTCmeds) Include Herbs/Vitamins/Dietary Supplements

Example: Aleve

Signature: _____ Date: _____

Past Medical History

Conditions	Yes	No	Conditions	Yes	No
High Blood Pressure			Persistent Night Pain		
Heart Condition			Frequent/Severe Headaches		
Stroke (s)			Unexplained Weight Loss		
Mental Implants			Past or Current Bowel/Bladder Dysfunction		
Diabetes			Gynecological Issues		
Dizziness			Vaginal/Cesarean Birth (Number: _____)		
Light Headiness			Hearing Impairment		
Excessive Fatigue			Visual Impairment		
Broken Bones			HIV/Aids		
Fibromyalgia			Joint Replacements		
Arthritis / Gout			Osteoporosis		
Pacemaker/Aneurysm Clips			Anemia/Blood disease		
Seizures			Tuberculosis		
Cancer			Hepatitis/Liver Problems		
Shortness of Breath/Asthma			Skin Rashes/Hives		

OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS?

1.
2.
3.
4.
5.
6.

PREVIOUS PROCEDURES/SURGERIES?

NAME OF PROCEDURE/SURGERY	**DATE PERFORMED**
1.	
2.	
3.	
4.	
5.	

ALLERGIES:

1.
2.
3.