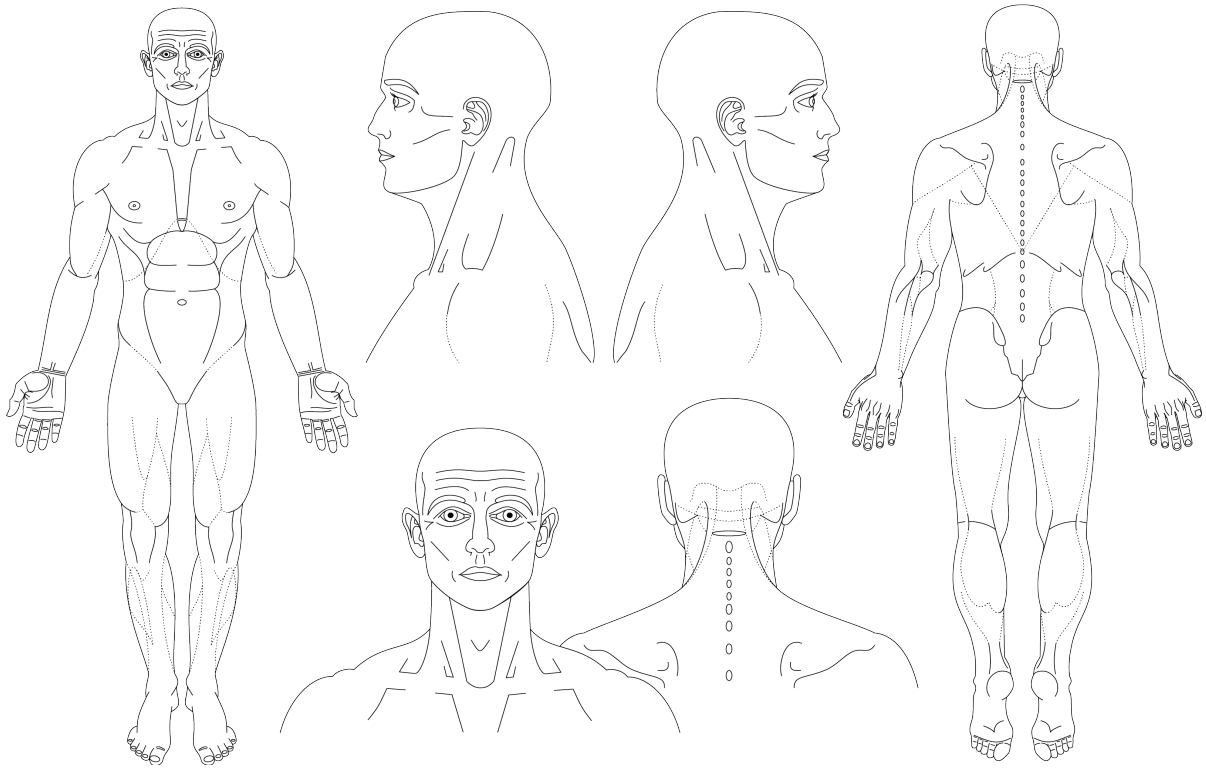
Patient Intake & History

PATIENT DATA							
Name (Last, First, M.I.)		☐ M ☐ F		Birth Date:			Age:
Address	Apt.		City		State		Zip
Phone (Cell):	Provider*			Phone (Other):			
Email*				Social Security (Required)			
Occupation:				Employer:			
Marital Status: ☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed		
Spouse's Name:				Phone:		☐ Use as Emergency Contact	
Emergency Contact:				Phone:		Relationship	

* *Your Email and Phone Numbers will NOT be shared with any 3rd parties and is used for occasional office announcements and appointment reminders.*

CHIEF COMPLAINT			**DATE OF INJURY:**	
Cause of Condition:	☐ Injury/Trauma	☐ Motor Vehicle	☐ Unknown	☐ Other

PLEASE USE THE FOLLOWING LETTERS TO INDICATE WHERE YOUR SYMTPOMS ARE ON THE BODY DIAGRAMS BELOW							
A = Ache	B = Burning	N = Numb	S =Sharp	D = Dull	P = Pins	X = No Feeling	O = Other



PLEASE CHECK IF YOU SUFFER FROM ANY OF THE FOLLOWING (OR ADD IF NOT LISTED):			
☐ Alcoholism	☐ Diabetes - Type:	☐ Loss of Memory	☐ Swollen Ankles
☐ Allergies	☐ Digestion Problems	☐ Loss of Balance	☐ Swollen Joints
☐ Anemia	☐ Dizziness	☐ Loss of Smell	☐ Thyroid
☐ Arteriosclerosis	☐ Ear Ringing (Tinnitus)	☐ Loss of Taste	☐ Tuberculosis
☐ Arthritis (Osteo)	☐ Excessive Menstruation	☐ Neck Pain	☐ Ulcers
☐ Arthritis (Rheumatoid)	☐ Eye Pain	☐ Nervousness	☐ Varicose Veins
☐ Asthma	☐ Fatigue	☐ Nose Bleeds	☐ Venereal Disease
☐ Back Pain	☐ Frequent Urination	☐ Pacemaker	☐
☐ Breast Lump(s)	☐ Headaches/Migraines	☐ Polio	☐
☐ Bronchitis	☐ Heart Disease	☐ Poor Posture	☐
☐ Bruise Easily	☐ Hemorrhoids	☐ Prostate Problems	☐
☐ Cancer	☐ High Blood Pressure	☐ Sciatica	☐
☐ Chest Pain	☐ Hot Flashes	☐ Shortness of Breath	☐
☐ Cold Arms or Legs	☐ Irregular Heartbeat	☐ Sinus Infection	☐
☐ Constipation	☐ Irregular Menstrual Cycle	☐ Sleep Problems (Insomnia)	☐
☐ Cramps (Muscle)	☐ Kidney Infection	☐ Spinal Curvatures	☐
☐ Depression	☐ Kidney Stones	☐ Stroke	☐

PATIENT HISTORY					
Childhood Illness:					
☐ Measles	☐ Mumps	☐ Rubella	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio
Immunizations and dates:	☐ Influenza		☐ Chickenpox		☐ Hepatitis
	☐ Pneumonia		☐ Tetanus		☐ MMR (*Measles, Mumps, Rubella)*

List any DIAGNOSED health issues.			
1.	Year	5.	Year
2.		6.	
3.		7.	
4.		8.	

Surgeries	☐ None
Year	Reason

Hospitalizations	☐ None
Year	Reason

Date of last X-Rays (past 24 months):	**Reason for X-Rays:**	☐ None

Have you ever had a blood transfusion?	☐ Yes	☐ No

List current Prescription drugs and Over-the-Counter drugs. Include Vitamins and Inhalers.

Name	Reason	Start Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies		☐ None
1.	3.	
2.	4.	

HEALTH HABITS						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., stretching, climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e. weights, cardio, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e.,work or recreation 4x/week for 30 minutes or more)					
Sleep	Difficulty falling asleep?				☐ Yes	☐ No
	Awakened at night from pain?				☐ Yes	☐ No
	Awakened at night to go to bathroom?				☐ Yes	☐ No
	Quality of sleep? ☐ Poor ☐ Fair ☐ Good ☐ Excellent			Hours of sleep?		
Diet	Are you currently on a specific diet or weight-loss program?				☐ Yes	☐ No
	How many meals per day?		How many snacks per day?			
	Salt	☐ None	☐ Low	☐ Medium	☐ High	
	Fat	☐ None	☐ Low	☐ Medium	☐ High	
	Protein	☐ None	☐ Low	☐ Medium	☐ High	
	Carbohydrate (bread, pasta, etc.)	☐ None	☐ Low	☐ Medium	☐ High	
	Sugars (snacks, drinks, food)	☐ None	☐ Low	☐ Medium	☐ High	
	Caffeine	☐ None	☐ Low	☐ Medium	☐ High	
	Water	☐ None	☐ Low	☐ Medium	☐ High	
Alcohol	Do you consume alcohol?				☐ Yes	☐ No
	Select which type.	☐ Beer	☐ Wine	☐ Liquor	☐ Other	
	How many drinks per week?					

Tobacco	Do you currently use tobacco?		☐ Yes	☐ No
	Select which type.	☐ Cigarette ☐ Chew ☐ Cigar ☐ Pipe ☐ Other		
	How many times per day?	How many years?		
	Have you smoked previously? ☐ Yes ☐ No	How many years?		
Drugs	Do you currently use drugs recreationally? (Please list)		☐ Yes	☐ No
	1.	3.		
	2.	4.		
Sex	Are you sexually active?		☐ Yes	☐ No
	If Yes, are you trying for pregnancy?		☐ Yes	☐ No
	Are you currently using contraceptives?		☐ Yes	☐ No
	If Yes, what kind(s)?			
	Any discomfort during intercourse?		☐ Yes	☐ No
Mental Health	Is stress a major problem for you?		☐ Yes	☐ No
	Do you panic when stressed?		☐ Yes	☐ No
	Do you have a high level of anxiety?		☐ Yes	☐ No
	Do you have panic attacks?		☐ Yes	☐ No
	Do you have any eating disorders?		☐ Yes	☐ No
	Do you have trouble sleeping?		☐ Yes	☐ No
	Do you feel depressed?		☐ Yes	☐ No
	Have you ever thought about or attempted suicide?		☐ Yes	☐ No
	Have you ever thought about hurting yourself or attempted to hurt yourself, or others?		☐ Yes	☐ No
	Have you ever been to a counselor, therapist, psychologist, or psychiatrist?		☐ Yes	☐ No

WOMEN ONLY			
Age at onset of menstruation:			
Date of last menstruation:	Period every _____ days.		
Number of pregnancies?	Number of live births?		
Are you or maybe currently pregnant?		☐ Yes	☐ No
Are you trying for pregnancy?		☐ Yes	☐ No
Are you breastfeeding?		☐ Yes	☐ No
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Have you had a D&C (Dilation & Curettage)? *If Yes, please provide date.*		☐ Yes	☐ No
Have you had a hysterectomy? *If Yes, please provide date.*		☐ Yes	☐ No
Have you had a Cesarean (C-section)? *If Yes, please provide date.*		☐ Yes	☐ No
Do you feel pain or burning with urination?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No
Any blood in your urine?		☐ Yes	☐ No
Any problems with control of urination?		☐ Yes	☐ No
Any hot flashes or sweating at night?		☐ Yes	☐ No
Do you have excessive menstrual pain, headaches, or other symptoms at or around time of period?		☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No
Date of last pelvic exam *(if abnormal, explain)*:			

MEN ONLY		
Do you usually get up to urinate during the night? If Yes, number of times _____	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate problems within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testiclular pain or swelling?	☐ Yes	☐ No
Date of last rectal exam *(if abnormal, explain)*?		

OTHER			
Check if you have or had any symptoms in the following areas to a significant degree and briefly explain.			
☐ Skin	☐ Head/Neck	☐ Ears	
☐ Nose	☐ Throat	☐ Lungs	
☐ Chest/Heart	☐ Back	☐ Intestine	
☐ Bladder	☐ Bowel	☐ Circulation	
Check if any recent changes in the following.			
☐ Weight	☐ Energy	☐ Sleep	☐ Other:
Complete loss of bladder control (urinary incontinence)? *If Yes, when?*		☐ Yes	☐ No
Complete loss of bowel control (fecal incontinence)? *If Yes, when?*		☐ Yes	☐ No

FAMILY HISTORY			
Are you adopted?		☐ Yes	☐ No
Mother	List all significant health problems.	3.	☐ History Unknown
	1.	4.	
	2.	5.	
Father	List all significant health problems.	3	☐ History Unknown
	1.	4.	
	2.	5.	
Grandmother (Maternal)	List all significant health problems.	3.	☐ History Unknown
	1.	4.	
	2.	5.	
Grandfather (Maternal)	List all significant health problems.	3.	☐ History Unknown
	1.	4.	
	2.	5.	
Grandmother (Paternal)	List all significant health problems.	3.	☐ History Unknown
	1.	4.	
	2.	5.	
Grandfather (Paternal)	List all significant health problems.	3.	☐ History Unknown
	1.	4.	
	2.	5.	

☐ **Sibling** ☐ **Child** ☐ **Other**	Age: ☐ M ☐ F	
	1.	4.
	2.	5.
☐ **Sibling** ☐ **Child** ☐ **Other**	Age: ☐ M ☐ F	
	1.	4.
	2.	5.
☐ **Sibling** ☐ **Child** ☐ **Other**	Age: ☐ M ☐ F	
	1.	4.
	2.	5.
☐ **Sibling** ☐ **Child** ☐ **Other**	Age: ☐ M ☐ F	
	1.	4.
	2.	5.
☐ **Sibling** ☐ **Child** ☐ **Other**	Age: ☐ M ☐ F	
	1.	4.
	2.	5.
☐ **Sibling** ☐ **Child** ☐ **Other**	Age: ☐ M ☐ F	
	1.	4.
	2.	5.

PATIENT SIGNATURE: ____ DATE: ___________________