

# 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

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

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:** \_\_\_\_\_ 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 \_\_\_\_\_

### 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 \_\_\_\_\_