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INTAKE FORM

PERSONAL INFORMATION: *(Please print clearly)*

Name: ______________________________
Last First Middle Initial

Home Address: ______________________________
Street City State Zip

Primary Telephone: ( ) ______________ Home Work Cell
Secondary Telephone: ( ) ______________ Home Work Cell

Date of Birth: __________ Sex: M / F Occupation: __________

Marital Status: S M W D Email: __________

Emergency Contact: __________ P: ( ) __________ Relationship: __________

MEDICAL INFORMATION:

Who referred you to our clinic: __________

Primary Physician: __________ Phone: ( ) __________

Referring Physician: __________ Phone: ( ) __________

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

1. What is the primary complaint that brings you in for treatment today?

   Secondary complaint?

   As a result, I am now having difficulty with:

2. When and how did your symptom(s) begin? Date: __________

3. Have you ever received the following treatment for this condition?

	Yes	No	How Long?	Helpful?
Physical Therapy	_____	_____	__________	Yes No
Myofascial Release	_____	_____	__________	Yes No
Chiropractic	_____	_____	__________	Yes No
Other: __________	_____	_____	__________	Yes No

4. Past Medical History (include dates of occurrence)

   Surgeries: __________

   Accidents: __________

5. List ALL medications which you are currently taking (include supplements, herbal and homeopathic remedies). Please include reason for medication.

____

____

6. Please place an "M" in front of each item that you experience at least MONTHLY. Place a "W" in front of each item that you experience WEEKLY or more frequently.

MUSCULO-SKELETAL:

_______ Headaches/migraines _______________
_______ Joint stiffness _______________
_______ Joint swelling _______________
_______ Spasms/cramps _______________
_______ Fractured bones _______________
_______ Strains/Sprains _______________
_______ Back/hip pain _______________
_______ Neck/shoulder pain _______________
_______ Arm/hand pain _______________
_______ Leg/foot pain _______________
_______ Jaw pain/TMJ _______________
_______ Tendonitis _______________
_______ Bursitis _______________
_______ Scoliosis _______________
_______ Arthritis _______________
_______ Osteoporosis _______________

CIRCULATORY/RESPIRATORY:

_______ Dizziness _______________
_______ Shortness of breath _______________
_______ Chest pain/tightness _______________
_______ Heart disease _______________
_______ Varicose Veins _______________
_______ Fainting _______________
_______ Cold feet/hands _______________
_______ Lymphedema _______________
_______ Excessing sweating _______________
_______ Sweaty palms _______________
_______ Blood clots _______________
_______ Allergies _______________
_______ Sinus condition _______________
_______ Asthma _______________
_______ Hi/Lo blood pressure _______________
_______ Diabetes _______________

DIGESTIVE/URINARY:

_______ Indigestion _______________
_______ Constipation _______________
_______ Diarrhea _______________
_______ Bowel irregularity _______________
_______ Liver Disease _______________
_______ Bloating/gas _______________
_______ Heartburn _______________
_______ Stomach cramps _______________
_______ Nausea/vomiting _______________
_______ Painful urination _______________
_______ Frequent urination _______________
_______ Urgent urination _______________
_______ Incomplete urination _______________
_______ Unable to hold urine _______________
_______ Kidney disease _______________

REPRODUCTIVE:

_______ Currently pregnant _______________
_______ Previous pregnancies _______________
_______ # pregnancies _______________
_______ # live births _______________
_______ # premature births _______________
_______ Periods _______________
_______ Irregular periods _______________
_______ Painful periods _______________
_______ PMS _______________
_______ Endometriosis _______________
_______ Menopause _______________
_______ Hot flashes _______________
_______ Breast lump/tender _______________
_______ Hysterectomy _______________
_______ Prostate condition _______________
_______ Impotence _______________

NERVOUS SYSTEM:

_______ Numbness/tingling _______________
_______ Twitching of face _______________
_______ Fatigue _______________
_______ Tired during day _______________
_______ Extreme fatigue _______________
_______ Chronic pain _______________
_______ Sleep Disorders _______________
_______ Epilepsy/Seizures _______________
_______ Stroke _______________
_______ Ulcers _______________
_______ Paralysis _______________

MISCELLANEOUS:

_______ Loss of appetite _______________
_______ Coughing _______________
_______ Stuffy nose, congestion _______________
_______ Vertigo/earache _______________
_______ Sore throat _______________
_______ Forgetfulness _______________
_______ Confusion _______________
_______ Hearing impaired _______________
_______ Difficulty concentrating _______________
_______ Visually impaired _______________
_______ Eyestrain _______________

M = MONTHLY **W = WEEKLY**

______	Herpes/shingles	______	______	Blurry vision	______
______	Cerebral palsy	______	______	Eye irritation	______
______	Chronic fatigue synd.	______	______	Eating disorder	______
______	Multiple Sclerosis	______	______	Fibromyalgia	______
______	Muscular dystrophy	______	______	Cancer	______
______	Parkinson's disease	______	______	Infectious Disease	______
______	Spinal cord injury	______	______	Rashes	______
			______	Athlete's foot	______
	PSYCHOLOGICAL:		______	Metal Implants	______
______	Unable to cope	______	______	Alcohol use	______
______	Easily annoyed/irritated	______	______	Nicotine use	______
______	Depression	______	______	Caffeine use	______
______	Anxiety	______	______	Uninterested in sex	______
______	Difficulty with family	______	______	Unable to enjoy sex	______
______	Difficulty with friends	______	______	Water retention	______
______	Worrisome thoughts	______			
______	Recurring bad thoughts	______			
______	Thoughts of suicide	______			
______	Fearful of people/places	______			

7. If sleep is a problem, answer these questions:

Do you have trouble falling asleep? Yes No
Is your sleep restful? Yes No
How many times do you wake in the night? ____________________
How long before you fall back to sleep ____________________

8. Do you engage in regular exercise? Yes No

What type and how often? ____

____

Are you able to exercise now? Yes No

Do you have discomfort, shortness of breath, or pain with exercise? ______________

____

9. In general, your lifestyle is: 1 (Active) 2 3 (Average) 4 5 (Inactive)

10. Patient Goals: List the activities that you would like to be able to do as a result of therapy.

	Activity	Duration/How Often	By When
1			
2			
3			

Other Goals? ____

____

I have stated all medical conditions to the best of my knowledge and will update the therapist of any changes in my health status.

Client's Signature: ______________________________ Date: ____________