



INTAKE FORM

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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 _____
 _____ Cerebral palsy _____
 _____ Chronic fatigue synd. _____
 _____ Multiple Sclerosis _____
 _____ Muscular dystrophy _____
 _____ Parkinson's disease _____
 _____ Spinal cord injury _____

_____ Blurry vision _____
 _____ Eye irritation _____
 _____ Eating disorder _____
 _____ Fibromyalgia _____
 _____ Cancer _____
 _____ Infectious Disease _____
 _____ Rashes _____
 _____ Athlete's foot _____
 _____ Metal Implants _____
 _____ Alcohol use _____
 _____ Nicotine use _____
 _____ Caffeine use _____
 _____ Uninterested in sex _____
 _____ Unable to enjoy sex _____
 _____ Water retention _____

PSYCHOLOGICAL:

_____ Unable to cope _____
 _____ Easily annoyed/irritated _____
 _____ Depression _____
 _____ Anxiety _____
 _____ Difficulty with family _____
 _____ Difficulty with friends _____
 _____ 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 2 3 4 5
Active Average 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: _____