

## **INTAKE FORM**

## www.naturalbalancetherapy.com

PERSONAL INFORMATION	ON: (Please pri	nt clearly)				
Name:						
Las	st	First		N	1iddle Initia	al
Home Address:	Street		City	Sta	to.	Zip
	dicei		Oity			·
Primary Telephone: Secondary Telephone:	( )			Home Home	Work Work	Cell Cell
Date of Birth:	Sex:	M/F Occ	cupation:			
Marital Status: S M W	D Email:					
Emergency Contact:						
MEDICAL INFORMATION	l:					
Who referred you to our cli	inic:					
Primary Physician:			Phone: (	)		
Referring Physician:			Phone: (	)		
Please fill out these forms pain and functional status.	as specifically as	s possible to p	rovide us witi	h a clear pict	ure of yo	our present
1. What is the primar	y complaint that I	orings you in fo	or treatment to	oday?		
Secondary compla	aint?					
As a result, I am n	ow having difficul	ty with:				
2. When and how did	d your symptom(s	) begin? Date	:			
3. Have you ever rec	eived the following	ng treatment fo	r this condition	on?		
Physical Therapy Myofascial Relea Chiropractic			How Long?	Y	lelpful? es No es No es No	
Other:				V	es No	
4. Past Medical Histo	ory (include dates	of occurrence	)			
Surgeries:						

<ul> <li>Please place an "M" in front of each in front of each item that you experie</li> </ul>	item that you experience at least MONTHLY. Place
CULO-SKELETAL:	CIRCULATORY/RESPIRATORY:
Headaches/migraines	Dizziness
Joint stiffness	Shortness of breath
Joint swelling	Chest pain/tightness
Spasms/cramps	Heart disease
Fractured bones	Varicose Veins
Strains/Sprains	Fainting
Back/hip pain	Cold feet/hands
Neck/shoulder pain	 Lymphedema
Arm/hand pain	Excessing sweating
Leg/foot pain	Sweaty palms
Jaw pain/TMJ	Blood clots
Tendonitis	Allergies
Bursitis	Sinus condition
Scoliosis	Asthma
Arthritis	Hi/Lo blood pressure
Osteoporosis	Diabetes
STIVE/URINARY:	REPRODUCTIVE:
Indigestion	Currently pregnant
Constipation	Previous pregnancies
 Diarrhea	# pregnancies
Bowel irregularity	# live births
Liver Disease	# premature births
Bloating/gas	Periods
Heartburn	Irregular periods
Stomach cramps	Painful periods
Nausea/vomiting	PMS
Painful urination	Endometriosis
Frequent urination	Menopause
Urgent urination	Hot flashes
Incomplete urination	Breast lump/tender
Unable to hold urine	Hysterectomy
Kidney disease	Prostate condition
	Impotence
VOUS SYSTEM:	MISCELLANEOUS:
Numbness/tingling	Loss of appetite
Twitching of face	Coughing
Fatigue	Ctuffy need congestion
Tatigue Tired during day	Vertigo/earache
Extreme fatigue	Sore throat
Extreme ratigue Chronic pain	Forgetfulness
Sleep Disorders	Confusion
Sleep Disorders Epilepsy/Seizures	Confusion Hearing impaired
	Dearror moated

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engage in regular exe	ercise? Y	es No	)				
type and how often?							
able to exercise now	v? Yes	No					
			or noin i	uith ove	roio o ?		
u have discomfort, sh	ortness of	breath,	or pain v	with exe	ercise?		
al, your lifestyle is:	. 1	2	. 3	4	5		
	Active	,	Average		Inactive		
Goals: List the activit	ties that y	ou would	d like to b	e able	to do as	s a resu	ult of therapy
Activity			Ouration/H	How Of	ten	B	y When
C	Soals: List the activity	Active  Soals: List the activities that ye  Activity	Active  Soals: List the activities that you would Activity  Country	Active Average  Soals: List the activities that you would like to be  Activity Duration/H	Active Average  Soals: List the activities that you would like to be able  Activity Duration/How Of	Active Average Inactive  Soals: List the activities that you would like to be able to do as  Activity Duration/How Often	Active Average Inactive  Soals: List the activities that you would like to be able to do as a resundant formula in the control of the control

M = MONTHLY W = WEEKLY