CONFIDENTIAL PATIENT INTAKE

Legal Name (last, first, m.) : _____

Birth Date: _____ Age: _____ Patient's Sex: ○ Male ○ Female Marital Status: S M W D P

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Occupation: _____

Work Phone: ( ) _____ Ext: _____ Email: _____

Emergency Contact: _____ Phone: ( ) _____

Preferred Name (if different from above): _____ Referred By: _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ○ Pregnancy ○ *current* ○ *former*
- ○ Stroke
- ○ High Blood Pressure
- ○ Heart Attack(s)
- ○ Diabetes
- ○ Blood Clots(s)
- ○ Varicose Veins
- ○ Pacemaker
- ○ Cancer/tumors
- ○ Skin Cancer
- ○ Numbness & Tingling
- ○ Arthritis
- ○ Infectious disease(s)
- ○ Athletes foot
- ○ Herpes/cold sores
- ○ Shingles
- ○ Rashes
- ○ Warts
- ○ Cigarette smoker
- ○ Contact lenses
- ○ Ruptured disk(s)
- ○ Herniated disk(s)
- ○ Bursitis
- ○ Scoliosis
- ○ Neck pain
- ○ Back pain
- ○ Low back pain
- ○ Shoulder pain
- ○ Headaches
- ○ Migraines
- ○ Broken bone(s)
- ○ TMJ

Please use the space below to provide additional information concerning those items checked above, or any other health related conditions you have experienced in the recent past, or anything in addition you may want us to know.

_____

_____

Please list below any medications or supplements (including Ibuprofen or Aspirin) you are currently taking.

_____

_____

Please indicate any allergies you may have including but not limited to nuts, aloe, lavender, herbs, foods, coconut, etc.

_____

_____

By signing below I acknowledge that the above information is complete and accurate to the best of my knowledge at this time.

_____ _____

Patient Signature *(In the case of a minor, parent or guardian must sign)* **Date**

CONFIDENTIAL PATIENT INTAKE CONTINUED

IF WE ARE BILLING YOUR INSURANCE, OR PLAN TO IN THE FUTURE, THIS PAGE IS REQUIRED

The reason for this visit : ○ PIP (automobile accident) ○ L&I (on the job injury) ○ Medical Insurance

Name of Insurance _____

Policy holder's name _____ Employer _____

SS# of policy holder _____ Date of birth _____

Insured's Gender: ○ Male ○ Female SS# of patient _____

Physician _____ Permission to consult with you physician? Y N

Chief Complaint _____

List of symptoms _____

When did this start _____ How did this start? _____

○ Is it getting better? ○ Worse? ○ Unchanged?

List any other Doctors, Therapists, or Practitioners you have seem for this condition:

1._____ 3._____

2._____ 4._____

What were you told? _____

_____

What type of treatment did you receive? _____

_____

Please list previous accidents or injuries (auto, work, falls, etc.) including dates:

1._____ 3._____

2._____ 4._____

Please list any previous surgeries, including dates:

1._____ 3._____

2._____ 4._____

Is there anything else that is causing you considerable concern, worry or increased stress? _____

_____

By signing below I acknowledge that the above information is complete and accurate to the best of my knowledge at this time.

_____ _____

Patient Signature *(In the case of a minor, parent or guardian must sign)* **Date**