Patient Intake Form		Name:	Date:		
Patient information contained	within this form is considered	Insurance:		(dd/mm/yr)	
Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the		Date of Birth:	□ male □ female		
		Address:			
				– Marital status	
best possible treatment.	,			S M W D SEP	
		Phone #: home:			
		E-mail address:			
		Occupation:			
		Occupation.	Ellipioyel		
Mark (c)	for current problems, check	k ☑ and indicate the age when you	had any of the fol	lowing:	
General	Gastrointestinal	Cardiovascular		heck any of the conditions	
☐ Allergies	☐ Abdominal pain	☐ High blood pressure	•	ou have or have had:	
☐ Depression	□ Bloody or tarry stool	☐ Low blood pressure		Alcoholism	
☐ Dizziness	☐ Colitis / Crohn's	☐ Hardening of the arteries		Anemia	
☐ Fainting	□ Colon trouble	☐ Irregular pulse		Appendicitis	
☐ Fatigue	☐ Constipation	☐ Pain over heart] Arteriosclerosis	
□ Fever	□ Diarrhea	☐ Palpitation		∃ Asthma	
☐ Headaches	☐ Difficult digestion	☐ Poor circulation		Bronchitis	
☐ Loss of sleep	☐ Diverticulosis	☐ Rapid heart beat] Cancer	
☐ Mental illness	☐ Bloated abdomen	☐ Slow heart beat		Chicken pox	
□ Nervousness	☐ Excessive hunger	☐ Swelling of ankles		Cold sores	
☐ Tremors	☐ Gallbladder trouble	□ Swelling of ankles		Diabetes	
	☐ Hernia	Poppiratory.] Eczema	
☐ Weight loss / gain	☐ Hemorrhoids	Respiratory ☐ Chest pain] Edema	
Mussals / Isint		·] Emphysema	
Muscle / Joint ☐ Arthritis / rheumatism	☐ Intestinal worms	☐ Chronic cough] Epilepsy	
	☐ Jaundice	☐ Difficulty breathing] Goiter	
☐ Bursitis	☐ Liver trouble	☐ Hay fever		Gout	
☐ Foot trouble	☐ Nausea	☐ Shortness of breath		Heart burn	
☐ Muscle weakness	□ Painful defication	☐ Spitting up phlegm / blood		Heart disease	
☐ Low back pain	□ Pain over stomach	☐ Wheezing		Hepatitis	
□ Neck pain	□ Poor appetite			Herpes	
☐ Mid back pain	□ Vomiting	Women only		•	
☐ Joint pain	☐ Vomiting of blood	□ Congested breasts		High cholesterol	
		☐ Hot flashes] HIV/AIDS	
Skin ☐ Boils	Genitourinary	□ Lumps in breast] Influenza	
	☐ Bed-wetting	☐ Menopause] Malaria	
☐ Bruise easily	☐ Bladder infection	□ Vaginal discharge] Measles	
☐ Dryness	☐ Blood in urine	Menstrual flow		☐ Miscarriage	
☐ Hives or allergies	☐ Kidney infection	☐ Reg. ☐ Irreg. ☐ Pain / cra	amps	Multiple sclerosis	
☐ Itching	☐ Kidney stones	Days of flow: Lenght of cyc] Mumps	
☐ Rash	□ Prostate trouble	Date - 1st day last period:		☐ Numbness/tingling	
☐ Varicose veins	□ Pus in urine	Are you pregnant? ☐ yes, ☐ no		Pace maker	
	☐ Stress incontinence	If yes, how many months?		Osteoporosis	
Eye, Ear, Nose & Throat	Urination] Pneumonia	
☐ Colds		How many children do you have?		Polio	
☐ Deafness	☐ Overnight more than twice			Rheumatic fever	
☐ Ear ache	☐ More than 8x in 24hrs	Date of last PAP test:] Stroke	
☐ Eye pain	☐ Decreased flow/force	☐ normal, ☐ abnorm	nal	Thyroid disease	
☐ Gum trouble	☐ Painful urination	Date of last mamogram:		Tuberculosis	
☐ Hoarseness	☐ Urgency to urinate	□ normal, □ abnorm	nai	Ulcers	
☐ Nasal obstruction				1 010013	
☐ Nose bleeds	pi	D 41			
☐ Ringing of the ears	Please list any me	edication you are currently taking a	ind why:		
☐ Sinus infection					
☐ Sore throat					
☐ Tonsilitis					
☐ Vision problems					

Patient Intake Form (side Give a breif detailed description of the	•	encing:					
	, ,	. .					
How long have you had this condition?							
Does it bother you (check appropriate	box): □ work, □ sleep, □ other:						
What seemed to be the initial cause: _							
		you area(s) of pain	on the figure be	low			
Please place a mark at the level of your pain on the scale below: Worst Possible T Pain No Pain		you area(s) or paint	on the ingular per				
Doot hoolth history			Habits	none	light	mod	haann
Past health history	Yes No If yes, explain breif	1,	Alcohol				heavy
Have you been hospitalized in the last 5 year?	•	•	Coffee				
had any mental disorders?			Tobacco				
had any broken bones?			Drugs				
had any strains or sprains?			Exercise				
ever used orthotics?	0 0		Sleep				
Do you take minerals, herbs or vitamins			Soft drinks				
How is most of your day spent? stan			— Salty foods				
How old is your matress?			— Water				
When was your last physical exam?			Sugar				
Family history If any blood rel	lative has had any of the follow	ina conditions, plea	nse check and in	dicate	whic	h rela	tive(s)
□ Alcoholism	□ Cancer	•	blood pressure			- 2.01	- 1-/
□ Anemia	□ Diabetes		cholesterol				
□ Arteriosclerosis	□ Emphysema		ole sclerosis				
□ Arthritis	□ Epilepsy		porosis				
□ Asthma	□ Glaucoma	□ Strok					
□ Bleed easily	□ Heart disease		id disease				