



## **PATIENT INTAKE FORM**

Patient Name: \_\_\_\_\_

What are we seeing you for? \_\_\_\_\_

What was the cause of your injury/symptoms? \_\_\_\_\_

Have you ever had these symptoms in the past? YES or NO

If you circled YES for the same or similar symptoms, who did you see?

\_\_\_\_\_

Are you currently being treated for your symptoms? YES or NO If YES circle which apply:

Chiropractor Medical Doctor Physical Therapist What tests have you had for your symptoms

and when were they performed? XRAY \_\_\_\_\_ MRI \_\_\_\_\_ CT \_\_\_\_\_ EMG \_\_\_\_\_

OTHER: \_\_\_\_\_ Please list any surgeries or treatment you have previously received:

\_\_\_\_\_

\_\_\_\_\_

Have you had any falls in the past year? \_\_\_\_\_

What is your goal for therapy? \_\_\_\_\_

Rate your pain over the last 2 weeks from 0—10

0 = None 10 = Extreme

Best: \_\_\_\_\_ Worst: \_\_\_\_\_ Current: \_\_\_\_\_



## MEDICAL HISTORY

Any allergies? \_\_\_\_\_

Please list all current Medications, Supplements, and Vitamins being taken at this time:

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Do you have any of the following? Check all that apply

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Chest Pain/Angina
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Asthma
- ☐ Heart Palpitations
- ☐ Stroke/CVA
- ☐ Liver/ Gallbladder Problems
- ☐ Kidney Problems
- ☐ Bowel/ Bladder Abnormalities
  - Difficulty emptying bladder
    - ☐ Painful urination
    - ☐ Urine Leakage
    - ☐ Constipation
- ☐ Recent Fractures or Surgeries
  - ☐ Metal Implants
  - ☐ Seizures
  - ☐ Dizziness/Fainting
  - ☐ Nausea/Vomiting

- ☐ Special Diet Guidelines
- ☐ Hernia
- ☐ Are you pregnant?
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Ringing in your ears
- ☐ Headaches
- ☐ Cancer or History of Cancer
- ☐ Smoking
- ☐ Skin Abnormalities
- ☐ Other \_\_\_\_\_