

PATIENT INTAKE FORM

Patient Name _____ Date of Birth: _____ Date _____

Drivers license #: _____ SSN: _____ Email _____

Age _____ Gender _____ Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Children _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Patient Primary Language _____

Occupation _____ Employer _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Please fill out insurance info, if applicable, and hand insurance card to receptionist to copy.

Subscriber Name _____ Health Plan _____

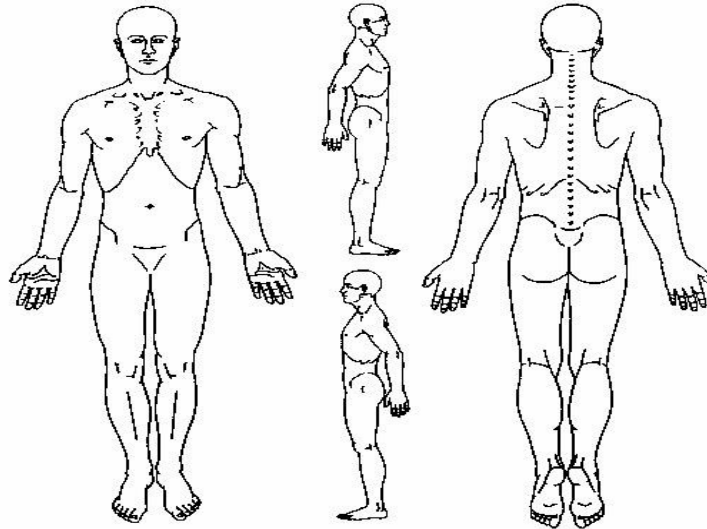
Subscriber ID# _____ Group # _____ Spouse Name _____

Spouse Employer _____ City _____ State _____ Zip _____

Primary Care Physician Name _____ PCP Phone (_____) _____

Medicare# _____ (if applicable)

Mark an X on the picture where you have pain/discomfort:



Describe your current problem and how it began:

Headache

Neck Pain

Mid-back Pain

Low Back Pain

Other: _____

Is this? Work Related Auto accident other

Date Problem Began _____

How Problem Began _____

How would you rate your pain today?					
0	2	4	6	8	10
No Pain					Worst

How often are your symptoms present?

(Occasional) 0 – 25% 26 -50% 51-75% 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

0	1	2	3	4	5	6	7	8	9	10
No Interference										Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCANS FOR YOUR AREA(S) OF COMPLAINT? Yes No

Date(s) taken _____ **What areas were taken?** _____

Please check all of the followings that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, ect.) | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pill | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Surgeries _____ | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Epilepsy/Seizures (explain) _____ | |
| <input type="checkbox"/> Other Health Problems (explain) _____ | |
| <input type="checkbox"/> Medications (please list) _____ | |

Family History:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Problems/Stroke | <input type="checkbox"/> Rheumatoid Arthritis | |

I certify to the best of my knowledge, the above information is complete and accurate. I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. If I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable. All cancellations must be made 24 hours in advance. "No Show" and Late Cancellations will be assessed a \$25 fee.

Patient Signature _____ **Date** _____