NEW PATIENT INTAKE FORMS

NEW PATIENT INTAKE FORM

Name

Sex:

(•) Male ( ) Female

Height

Weight

Occupation

Address *

Address Line 2 *

Martial Status:

( ) Single ( ) Married ( ) Widowed
( ) Divorced ( ) Separated ( ) Minor

Date of Birth

Emergency Contact: Name/Relationship/Phone

How did you hear about us?

[ ] Newspaper/Magazine [ ] Drive-by [ ] Yelp
[ ] Facebook [ ] Google Ads [ ] BNI

Referral/Other:

Internet Search / Other

HEALTH HISTORY

MAIN COMPLAINTS

If you could get rid of any health problems what would you want to get rid of. (please list in the order of importance below), and we will let you know if we can help.

#1 Complaint

INTENSITY

On a scale of "1 to 10", please rate the intensity of your chief complaint (0= no discomfort, 10 = extreme discomfort) Please take some time to be specific. This way we can use this to gauge progress we're making.

#1 on AVERAGE is:

#1 on WORSE is:

	1	1
#2 Complaint	#2 on AVERAGE is:	#2 on WORSE is:
	1	1
#3 Complaint	#3 on AVERAGE is:	#3 on WORSE is:
	1	1

Onset

For each condition listed above, please mark when you started experiencing them?

What have you tried doing to resolve these problems that DID NOT work?

The definition "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or the treatment did not restore your body's own ability to heal itself.

#1 Complaint

What have you tried for the #1 Complaint

#2 Complaint

What have you tried for the #2 Complaint

#3 Complaint

What have you tried for the #3 Complaint

Frequency

Please Check the box that best represent how frequent you feel your Complaint(s)

How frequent do you feel #1 Complaint?

☐ Daily ☐ Weekly ☐ Monthly

How frequent do you feel #2 Complaint?

☐ Daily ☐ Weekly ☐ Monthly

How frequent do you feel #3 Complaint?

☐ Daily ☐ Weekly ☐ Monthly

Duration

When you are feeling your symptoms, how long do you symptoms last?

How long does you #1 Complaint last?

☐ Minutes ☐ Hours ☐ Constant

How long does you #2 Complaint last?

☐ Minutes ☐ Hours ☐ Constant

How long does you #3 Complaint last?

☐ Minutes ☐ Hours ☐ Constant

What Aggravates or Alleviates you Chief Complaints?

What AGGRAVATES the #1 Complaint?

What ALLEVIATES the #1 Complaint?

What AGGRAVATES the #2 Complaint?

What ALLEVIATES the #2 Complaint?

What AGGRAVATES the #3 Complaint?

What ALLEVIATES the #3 Complaint?

How do your health problems interfere with the following areas of your life?

How are your health problems interfering with your Work?

How are your health problems interfering with your Family?

How are your health problems interfering with your Hobbies?

How have you taken care of your health in the past?

- [ ] Medications
- [ ] Surgery
- [ ] Injections
- [ ] Physical Therapy
- [ ] Dietary Modifications
- [ ] Vitamins & Supplements
- [ ] Acupuncture
- [ ] Excerise
- [ ] Chiropractic
- [ ] Arrosti
- [ ] Massage
- [ ] Herbal Medicine

How did above methods work for you? If other, please list them here.

Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

- ◯ Yes
- ◯ No

How physically demanding is your Job?

- [ ] Sitting
- [ ] Standing
- [ ] Moving

What is your daily/weekly intake of Nicotine/Tobacco?

What is your daily/weekly intake of Caffeine?

What is your daily/weekly intake of Alcohol?

Please check to indicate if you have ever had any of the following:

- [ ] Aids/HIV
- [ ] Anemia
- [ ] Bladder Diseases / UTI
- [ ] Alcoholism
- [ ] Anorexia
- [ ] Bleeding Disorders
- [ ] Allergy Shots
- [ ] Autoimmune Disorder
- [ ] Blood Pressure Too High or Too Low

- [ ] Bulimia
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Chicken Pox
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Epilepsy
- [ ] Gall Bladder Diseases
- [ ] Goiter
- [ ] Gonorrhea
- [ ] Gout
- [ ] Heart Diseases
- [ ] Hepatitis
- [ ] Infertility
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Sugar
- [ ] Lung Disease
- [ ] Measles
- [ ] Mononucleosis
- [ ] Multiple Sclerosis
- [ ] Mumps
- [ ] Neuropathy
- [ ] Pacemaker/ Defibrillator
- [ ] Paralysis / Semi-Paralysis
- [ ] Parkinson's Disease
- [ ] Polio
- [ ] Prostate Problems
- [ ] Prosthesis
- [ ] Psychiatric Care
- [ ] Scarlet Fever
- [ ] Skin (Rash, Eczema, Psoriasis)
- [ ] Stomach Ulcers
- [ ] Stroke
- [ ] Suicide Attempt
- [ ] Thyroid Disease (Hyper/Hypo)
- [ ] Tuberculosis
- [ ] Typhoid Fever
- [ ] Whooping Cough

Addictions

Cancer? What Type?

List ALL disorders you are CURRENTLY being treated for (include the dates of when you were diagnosed):

Anything We Missed or You Want To Tell Us?