



## INTAKE FORM

### Patient Information

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_ (optional)  
Alternate Phone: ( ) \_\_\_\_\_ ( ) Work \_\_\_\_\_ ( ) Cell \_\_\_\_\_  
Email Address: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
PCP: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Primary Insurance Policy Holder Information:

Relation to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_  
Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_ (optional)  
Alternate Phone: ( ) \_\_\_\_\_ ; ( ) Work \_\_\_\_\_ ( ) Cell \_\_\_\_\_

**\*If you have a secondary insurance, please let us know so we can get that information from you.\***

### Responsible Party for Co Pay/Co Insurance/Deductable Balance Due:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

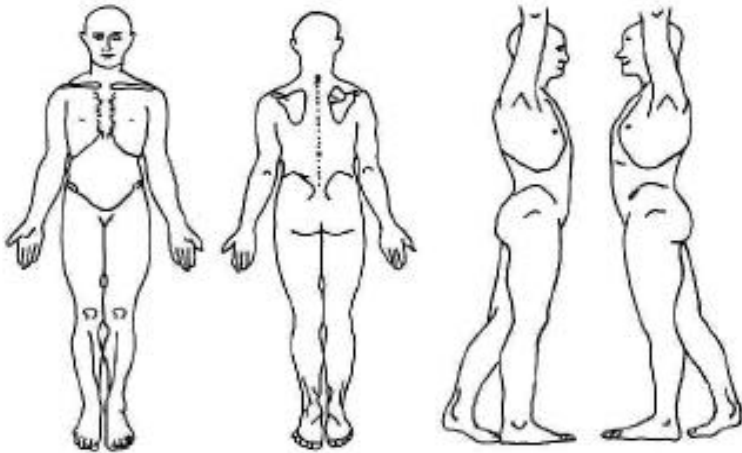
## MEDICAL QUESTIONNAIRE

NAME \_\_\_\_\_

1. How and when (date) did the present injury occur? \_\_\_\_\_  
\_\_\_\_\_

2. What are your functional problems with this condition? \_\_\_\_\_  
\_\_\_\_\_

3. Indicate on body diagram where your pain is located.



4. On a scale of 0-10(10 being excruciating) how painful was it when it started? (circle number)

1 2 3 4 5 6 7 8 9 10

5. What is it at its best and worst? (circle number)

1 2 3 4 5 6 7 8 9 10

6. How is it today? (circle number)

1 2 3 4 5 6 7 8 9 10

7. Describe the pain (i.e. sharp, dull, ache, numb, etc)

\_\_\_\_\_

8. What activities make your pain worse?

\_\_\_\_\_  
\_\_\_\_\_

9. What if anything eases your pain? \_\_\_\_\_

10. Do you have any problems with your bowels or bladder? \_\_\_\_\_

11. Have you had anything similar before? \_\_\_\_\_

12. What started this problem? \_\_\_\_\_

13. Have you had diagnostic medical tests for this, if so where can they be located? \_\_\_\_\_  
\_\_\_\_\_

14. Please list all medications, dosage and purpose.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Do you smoke tobacco? \_\_\_\_\_

16. Please list all surgeries and approximate dates.

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17. Have you seen anyone else for this problem? If so, please list.

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18. Do you exercise regularly? \_\_\_\_\_

**Past or current medical history; check all that apply:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Heartburn        | <input type="checkbox"/> Upset stomach     | <input type="checkbox"/> Thyroid condition    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Low blood sugar  | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Joint disease    | <input type="checkbox"/> Swelling          | <input type="checkbox"/> Fractures            |
| <input type="checkbox"/> Vision problems         | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Psoriasis               | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Dizziness/Fainting   |
| <input type="checkbox"/> Metal or other implants | <input type="checkbox"/> Tumor/cyst       | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Other                   |   |  |   |

19. What are your goals with therapy? \_\_\_\_\_

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To the best of my knowledge, the information I have provided is accurate and complete.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician's Signature

