



INTAKE FORM

Patient Information:

Name: _____ Birth Date: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Work() _____ Cell() _____
Email Address: _____ Would you like to receive our newsletter? YES __ NO __
Employer: _____ Occupation: _____
PCP: _____ Diagnosis: _____
Do we have your permission to send a report to your PCP? YES __ NO __
How did you hear about us? _____

Emergency Contact:

Name: _____ 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 () _____ 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/Deductible Balance Due:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT.

Signature _____ Date _____

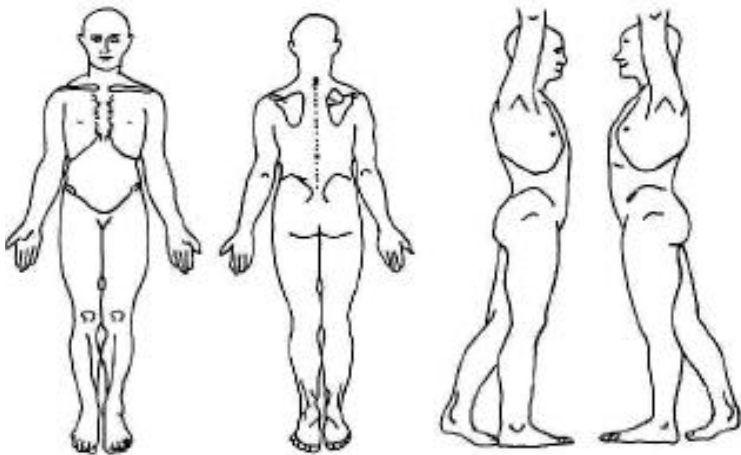
MEDICAL QUESTIONNAIRE

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.

(OVER)

