PATIENT INTAKE FORM
(Please print)

Name: _____ Today's date: _____ Height: _____Weight: _____
Date of Birth: _____ Age: _____ SSN: _____ ( ) Right handed ( ) Left handed
E-mail address:_____ Marital status: ( ) Married ( ) Partnered ( ) Single ( ) Widowed
Are there children or grandchildren in the home? Yes or No Ages of children: _____

What are your current symptoms? _____

What date did the symptoms begin? _____ What brought on the symptoms? _____

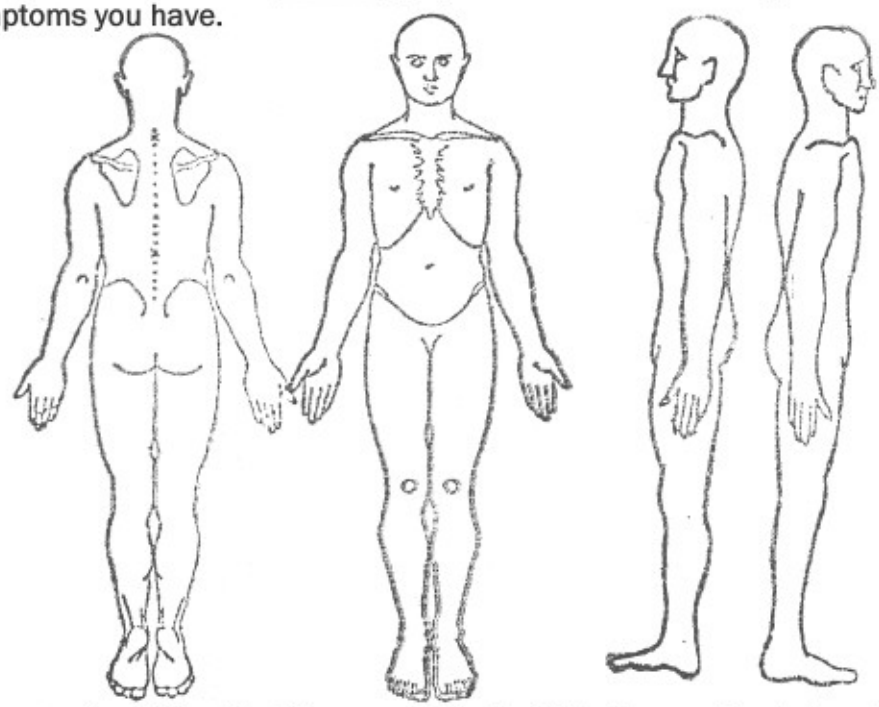
What do you do now to relieve symptoms? _____

Draw a circle around the activities that make your symptoms worse. Standing, sitting, driving, squatting, kneeling, running, walking, standing from a seated position, going up the stairs, going down the stairs, looking over my shoulder, reaching overhead, combing my hair, tucking in my shirt, typing, lying down, describe any other:

_____

On the diagram below please draw where the present symptoms occur. Use the legend on the left to indicate what type of symptoms you have.

**** numb, tingling
dull aching pain
>>>> sharp pain
++++ cold
bbbb burning



Please grade your pain on a scale of 0 to 10. 0 is no pain at all. 10 is the worst pain imaginable where you would have to be transported to the emergency room.

Little or no pain Unbearable

_____What is the pain level at this moment?
0 1 2 3 4 5 6 7 8 9 10

_____What is the BEST your pain has been over the last 2 weeks?
0 1 2 3 4 5 6 7 8 9 10

_____What is the WORST the pain has been in the last 2 weeks?
0 1 2 3 4 5 6 7 8 9 10

Little or no pain Unbearable

During the past 4 weeks how has your physical health interfered with your daily activities?
( )not at all ( )slightly ( )moderately ( )severely
What type of treatment have you received for this condition thus far? _____

_____

Have you ever had this or a similar condition previously? Yes or No Was there an effective treatment previously? Explain _____

_____

What is your occupation? _____
Place of Employment: _____
How long have you been at your current job? _____
List any restrictions you have at your place of employment: _____

In general, would you say your health is: ( ) good ( ) fair ( ) poor
Please state date and type of any surgeries: _____

_____

_____

Please list all medications you are currently taking for any condition.

_____

_____

_____

_____

Do you have any drug or skin allergies? Please List. _____

Do you smoke? Yes or No How many cigarettes per day? _____ How many years? _____

Do you drink: (Circle any that apply) tea, coffee or soda? How many per day? _____

Do you drink alcohol? Yes or No How Often? Daily Weekly Monthly Annually

Please answer yes or no to the following questions.

1. Have you ever been told you have osteoporosis or osteopenia?	Yes	No
2. Have you ever been told you have high blood pressure?	Yes	No
3. Have you ever had a heart attack?	Yes	No
4. Have you recently gained or lost weight?	Yes	No
5. Have you ever been diagnosed with cancer?	Yes	No
6. Have you had recent trouble balancing or coordinating?	Yes	No
7. Do you need glasses to see clearly?	Yes	No
8. Do you have trouble hearing out of one or both ears?	Yes	No
9. Do you ever have difficulty breathing?	Yes	No
10. Do you have spells of severe dizziness or vertigo?	Yes	No
11. Do you have diabetes (sugar disease)?	Yes	No
12. Have you ever been diagnosed with Hepatitis?	Yes	No
13. Have you ever been diagnosed with an autoimmune disorder?	Yes	No
14. Do you have any reason to believe you may be pregnant?	Yes	No
15. Do you have a seizure disorder/epilepsy	Yes	No