Patient Intake Form		Name:		Date:	
Patient information contained within this form is considered strictly confidential.		Insurance:		(dd/mm/yr)	
		Date of Birth:			
				🗆 male 🗆 female	
Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.		Address:		Marital atatua	
				Marital status	
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		Phone #: home:	work:		
		E-mail address:			
	-	Occupation:	Employer:		
Check ☑ and indicate	the age when you had any o	f the following:			
General	Gastrointestinal	Cardiovascular	Ch	eck any of the conditions	
☐ Allergies	☐ Abdominal pain	☐ High blood pressure	уо	u have or have had:	
☐ Depression	□ Bloody or tarry stool	☐ Low blood pressure		Alcoholism	
☐ Dizziness	□ Colitis / Crohn's	☐ Hardening of the arteries		Anemia	
☐ Fainting	□ Colon trouble	☐ Irregular pulse		Appendicitis	
☐ Fatigue	□ Constipation	☐ Pain over heart		Arteriosclerosis	
☐ Fever	☐ Diarrhea	☐ Palpitation		Asthma	
☐ Headaches	□ Difficult digestion	☐ Poor circulation		Bronchitis	
□ Loss of sleep	□ Diverticulosis	☐ Rapid heart beat		Cancer	
☐ Mental illness	□ Bloated abdomen	☐ Slow heart beat		Chicken pox	
☐ Nervousness	☐ Excessive hunger	☐ Swelling of ankles		Cold sores	
☐ Tremors	☐ Gallbladder trouble	-		Diabetes	
☐ Weight loss / gain	☐ Hernia	Respiratory		Eczema	
	☐ Hemorrhoids	☐ Chest pain		Edema	
Muscle / Joint	☐ Intestinal worms	☐ Chronic cough		Emphysema	
☐ Arthritis / rheumatism	☐ Jaundice	☐ Difficulty breathing		Epilepsy	
☐ Bursitis	☐ Liver trouble	☐ Hay fever		Goiter	
☐ Foot trouble	☐ Nausea	☐ Shortness of breath		Gout	
☐ Muscle weakness	☐ Painful deification	☐ Spitting up phlegm / blood		Heart burn	
□ Low back pain	☐ Pain over stomach	☐ Wheezing	_	Heart disease	
□ Neck pain	☐ Poor appetite	ŭ		Hepatitis	
☐ Mid back pain	☐ Vomiting	Women only		Herpes	
☐ Joint pain	☐ Vomiting of blood	☐ Congested breasts		High cholesterol	
	•	☐ Hot flashes		HIV/AIDS	
Skin □ Boils	Genitourinary	☐ Lumps in breast		Influenza	
	☐ Bed-wetting	☐ Menopause		Malaria	
☐ Bruise easily	☐ Bladder infection	☐ Vaginal discharge		Measles	
☐ Dryness	☐ Blood in urine	Menstrual flow		Miscarriage	
☐ Hives or allergies	☐ Kidney infection	☐ Reg. ☐ Irreg. ☐ Pain / cramps		Multiple sclerosis	
☐ Itching	☐ Kidney stones	Days of flow: Length of cycle:		Mumps .	
□ Rash	☐ Prostate trouble	Date - 1st day last period:		Numbness/tingling	
☐ Varicose veins	☐ Pus in urine	Are you pregnant? ☐ yes, ☐ no		Pace maker	
For For No. 9 Thousa	☐ Stress incontinence	If yes, how many months?		Osteoporosis	
Eye, Ear, Nose & Throat	Urination	How many children do you have?		Pneumonia	
□ Colds	Overnight more than twice	, ,		Polio	
□ Deafness	☐ More than 8x in 24hrs	Date of last PAP test:		Rheumatic fever	
☐ Ear ache	☐ Decreased flow/force	□ normal, □ abnormal		Stroke	
☐ Eye pain	☐ Painful urination	Date of last mammogram:		Thyroid disease	
☐ Gum trouble	☐ Urgency to urinate	□ normal, □ abnormal		Tuberculosis	
☐ Hoarseness	Jigoloj lo dililato	u normal, u abnormal		Ulcers	
☐ Nasal obstruction					
□ Nose bleeds	Please list anv me	dication you are currently taking and v	why:		
☐ Ringing of the ears	ione in a mini	Jee and seriously serious with			
☐ Sinus infection					
□ Sore throat					
☐ Tonsillitis					
☐ Vision problems	**************************************				

been hospitalized in the last 5 year?	Patient Intake Form (side 2) Give a brief detailed description of the problem you are currently experiencing.											
Does it bother you (check appropriate box): work, sleep, other:	Give a brief detailed description of the pi	roblem you are currently experience	encing:									
Does it bother you (check appropriate box): work, sleep, other:												
Does it bother you (check appropriate box): a work, a sleep, and other: What seemed to be the initial cause: Please mark you area(s) of pain on the figure below Please place a mark at the level of your pain on the scale below: Worst Possible Pain Pain Yes No If yes, explain briefly Liberal of the last 5 year? Liberal of the last 5 year. Liberal of the last 5 year. Liberal of the last 5	-											
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Please place a mark at the level of your pain on the scale below: Worst Possible Pain Past health history Have you Deen hospitalized in the last 5 year? In had any mental disorders? In had any strains or sprains? In ever used orthotics? Do you take minerals, herbs or vitamins? In ever used orthotics? Do you take minerals, herbs or vitamins? In ever used orthotics? In who dis your mattress? If you had any matter is not your day spent? standing, sitting, other: How is most of your day spent? standing, sitting, other: How do is your mattress? Family history If any blood relative has had any of the following conditions, please check and indicate which relative(s) Actionals Actionals If any blood relative has had any of the following conditions, please check and indicate which relative(s) Alcoholism Cancer High blood pressure High cholesterol Arteriascerosis Emphysema Multiple sclerosis Arthritis Epilepsy Osteoporosis Asthma Glaucoma Storke	Does it bother you (check appropriate bo	ox): 🗆 work, 🗆 sleep, 🗀 other:										
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had any broken bones? had any strains or sprains? ever used orthotics? ever used				l								
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Do you take minerals, herbs or vitamins?	•			1								
How is most of your day spent? standing, sitting, other: How old is your mattress? Water Sugar S				1 '								
How old is your mattress? When was your last physical exam? Family history If any blood relative has had any of the following conditions, please check and indicate which relative(s) Alcoholism Cancer High blood pressure Anemia Diabetes High cholesterol Arteriosclerosis Emphysema Multiple sclerosis Arthritis Epilepsy Osteoporosis Asthma Glaucoma Stroke	How is most of your day spent? standing	na 🗆 sittina 🗆 other:		1								
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Do you have any other health issues or concerns that our staff should be made aware of?	The second secon							manner of the contract of the				