



## Intake Form

### I. General Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex M F Email Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: Single Married Widow(er) Divorced

Emergency contact information: Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Are you currently under a physician's care? \_\_\_\_\_ For what reason? \_\_\_\_\_

Family Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

List all prescription medication you are currently taking: \_\_\_\_\_

List all non-prescription medication you are currently taking: \_\_\_\_\_

Are you under the care of any other type of health care worker? \_\_\_\_\_

If so, list name and phone number \_\_\_\_\_ How long have you been treated? \_\_\_\_\_

### II. Treatment Focus

Who referred you to this office? \_\_\_\_\_

What is your chief concern? \_\_\_\_\_

What are your goals for your health? \_\_\_\_\_

List current symptoms or problems. \_\_\_\_\_

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### III. Review Of Symptoms

Place an **X** next to any problems you currently have and a **P** next to problems you have had in the past.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> muscle cramps      | <input type="checkbox"/> difficult digestion | <input type="checkbox"/> osteoporosis            | <input type="checkbox"/> anemia                    |
| <input type="checkbox"/> insomnia           | <input type="checkbox"/> skin conditions     | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> diabetes                  |
| <input type="checkbox"/> fatigue            | <input type="checkbox"/> bone injuries       | <input type="checkbox"/> anxiety                 | <input type="checkbox"/> frequent colds and/or flu |
| <input type="checkbox"/> sinus pressure     | <input type="checkbox"/> headaches           | <input type="checkbox"/> varicose veins          | <input type="checkbox"/> neck pain                 |
| <input type="checkbox"/> cold hands/feet    | <input type="checkbox"/> heart disease       | <input type="checkbox"/> asthma                  |  |
| <input type="checkbox"/> sciatic            | <input type="checkbox"/> diarrhea            | <input type="checkbox"/> disc problems           |  |
| <input type="checkbox"/> heart palpitations | <input type="checkbox"/> constipation        | <input type="checkbox"/> vision problems         |  |

### IV. Medical History

Do you have allergies? If so, to what? \_\_\_\_\_

Recent Surgery? Describe: \_\_\_\_\_

Menstrual Problems? Clotting, Heavy/Light Flow, Irregularity, PMS, Spotting, Cramps: (Circle any that apply).

Is there any possibility of being pregnant? If so, in what week? \_\_\_\_\_

Muscle Tension? Indicate where:

