



Intake Form

I. General Information

Date _____

Name _____ Sex M F

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. _____

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:

