# Confidential Patient Intake Information

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

**Patient Information**

Patient Name_____
Today's Date_____ Date of Birth_____
Address_____
City_____ State_____ Zip_____
Gender Identification _____
Height_____ Weight_____
Marital Status (circle)
☑Single ☐Separated ☐Married ☐Divorced
☐Partnered ☐Widowed ☐Engaged ☐Minor

How many children do you have? _____
Please list any family members being treated here
_____
Occupation_____
Employer/School_____
Employer/School Address _____
_____
Employer/School Phone # _____

**Contact Information**

Home Phone_____
Cell Phone_____
Email Address_____
May we contact you via (circle preferable):
☐Home Phone ☐Cell ☐Email ☐None
Would you like to receive Newsletters by email?
☐Yes ☐No

In case of emergency please contact:
Name_____
Relationship_____
Phone_____
Alternate Phone_____

Spouse's/Partner's name_____
Spouse's/Partner's phone_____

How did you hear about us? _____

**Patient Condition**

What is your major complaint (be as specific as possible) _____
_____
When did your condition/symptoms/pain first appear?_____
Is this condition getting progressively worse (circle) ☐Yes ☐No ☐Constant ☐Comes & Goes
How long has it been since you really felt good?_____
Other doctors seen for this condition (circle) ☐Non ☐MD ☐DC ☐DO ☐DDS ☐ND ☐Other
If yes, when/by whom? _____

**Personal and Social Health History**

Are you currently pregnant, or do you think you may be pregnant? ☐Yes ☐No
How many hours per week do you typically work/attend school? ☑<20 ☐20 ☐30 ☐40 ☐40+
Do you exercise? ☑Yes ☐No If yes, how often and what type?_____
How would you rate your eat habits? ☐Excellent ☐Good ☐Could be better ☐Needs improvement
How well do you sleep? ☐Excellent ☐Good ☐Restless ☐Cant sleep ☐Wake up often
How many hours of sleep do you get daily? _____ Do you feel rested in the morning? ☐Yes ☐No
How is your energy overall? ☐Full power ☐OK ☐Low ☐Sporadic ☐Depend on caffeine for energy
How do you feel your immune system is working? ☐Strong ☐OK ☐Low
What do you hope to receive from our program? _____
_____

**Health History**

Do you have any allergies? (food, medications, environment) _____
List any prescribed medications, over the counter medications, vitamins, herbs and supplements _____
_____
When was your last: Physical exam_____ Blood/lab work_____ Imaging_____
Injuries/Surgeries you've had and when? _____
_____

Have you had or do you have any of the following conditions/diseases? Please circle

- Ankylosing spondylitis
- Anxiety
- Arthritis
- Asthma
- Bleeding disorder
- Blurred vision
- Bowel/bladder problems
- Buzzing in ear
- Cancer
- Carpal Tunnel
- Celiac disease
- Chest pains
- Chronic fatigue
- Cold hands or feet
- Colitis
- Compression fractures
- Connective tissue issues
- COPD
- Depression
- Diabetes
- Digestive/bowel problems
- Dizziness or vertigo
- Fibromyalgia
- Fusions (spinal, joint)
- Gout
- Hepatitis
- Herpes
- High blood pressure
- Hip replacement
- HIV/AIDS
- Kidney disease
- Knee surgery
- Liver Disease
- Marfan syndrome
- Multiple sclerosis
- Osteoporosis/penia
- Parkinson's disease
- Rotator cuff problem
- STI/STD
- Shoulder surgery
- Spinal surgery
- Stroke/TIA
- Thyroid problems
- Tuberculosis
- Other_____
- Other_____
- Other_____
- Other_____

Are there any conditions that run in your family? ☐ Yes ☐ No
If yes, what condition(s) and which family member(s)? _____

Thank you for completing our health care questionnaire