Patient Intake Form

Name: _____ **Date:** _____

Reason for today's visit: _____

_____

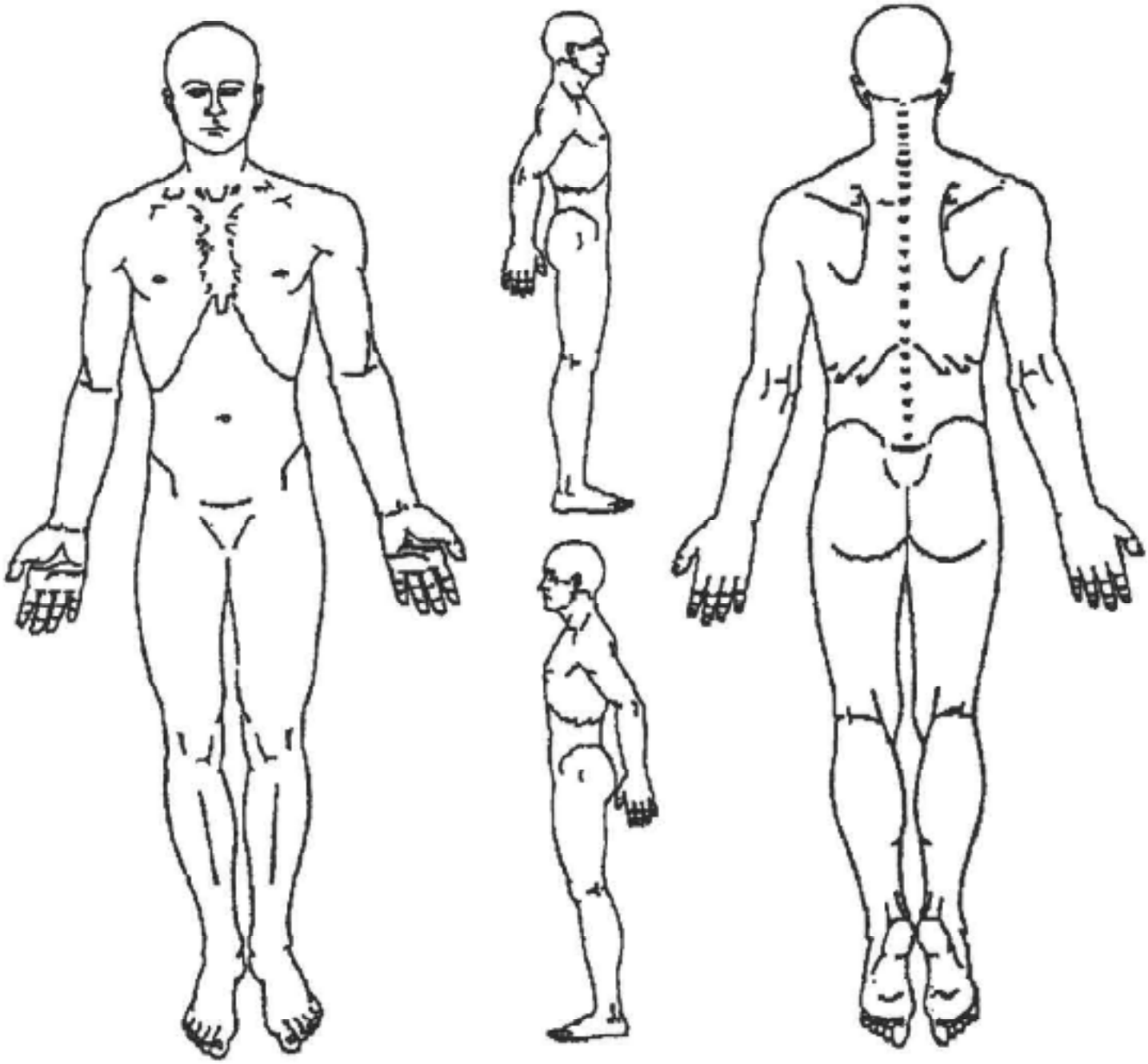
Did your injury occur during: __ work __ sports/ play __ auto accident __ routine/ household activity
When did your condition/ accident occur? _____
Where did your injury occur? _____
Please explain exactly how your injury occurred. _____

_____

Have you been injured previously? Please explain. _____

_____

Using the body charts, please circle all affected areas.



Have you been treated by a physician for this pain? If so, where? _____

_____

Please list all medications you are currently taking. _____

_____

Please list any medication allergies you may have. _____

_____

Do you have any of the following medical conditions?

__ heart attack/ stroke	__ heart surgery/pacemaker	__ heart murmur
__ congenital heart defect	__ mitral valve prolapse	__ artificial heart valves
__ alcohol/ drug abuse	__ veneral disease	__ hepatitis
__ anemia	__ diabetes	__ shingles
__ cancer	__ glaucoma	__ kidney problems
__ high blood pressure	__ psychiatric problems	__ rheumatic fever
__ headaches/ migraines	__ tuberculosis	__ ulcers/ colitis
__ seizures/ epilepsy	__ sinus problems	__ asthma/ emphysema
__ arthiritis	__ difficulty breathing	__ chemotherapy
__ low back problems	__ frequent neck pain	__ artificial joints

Please list any other medical conditions not mentioned above. _____

_____

Please list any past surgeries that you may have had. _____

_____

Do you smoke? If so, how much? _____

Do you drink alcohol? How much? _____

Do you use any other illegal drugs? _____

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____