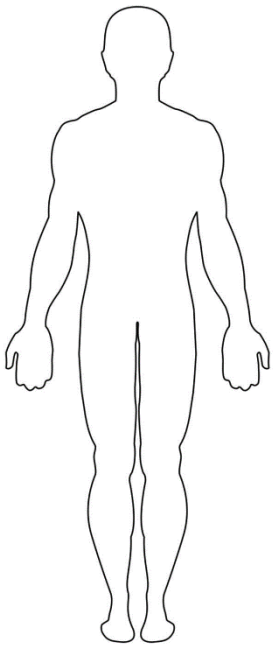
Intake Form

Name: _____ Date of Birth: _____ Date: _____

Referring Physician: _____ **(Circle Any Problematic Areas)**

Height_____ Weight_____



Symptoms List (Circle all that apply):

Neck Pain	Right / Left / Both
Low Back Pain	Right / Left / Both
Shoulder Pain	Right / Left / Both
Hip Pain	Right / Left / Both
Knee Pain	Right / Left / Both
Foot/Ankle Pain	Right / Left / Both
Headaches	
Other: _____	

Medication Allergies (Circle all that apply):

No Known Allergies / Latex / Adhesives / Iodine / Other:
_____

Past Surgical History: (List Any History)_____
_____

Other therapies you have tried (Circle all that apply):

Chiropractic / Physical Therapy / Acupuncture / Epidurals / Corticosteroids / Radio Frequency Ablations (RFA)

Past Medical History/ROS (Circle all that apply):

Heart: Hypertension / Vascular Disease / Heart Attacks / Arrhythmia / Bleeding Problems / High Cholesterol / Stroke

Lung: Sleep Apnea / COPD / Smoker / Asthma / Emphysema

Nervous System: Anxiety / Depression / Nerve Pain / Back Pain / Neck Pain / Headache / Migraines / Fibromyalgia / Seizures

Gastric/Endocrine: Reflux / Heart Burn / Diabetes / Hormonal Problems / Hyper/Hypo Thyroid

General: HIV / Hepatitis / Auto-Immune Disease / Cancer / Chronic Pain / Arthritis / Obesity / Musculoskeletal

Social History:

Do you Drink Alcohol, Smoke (Marijuana / Cigarettes), Chew Tobacco? If so, how often? _____

Are you currently or is there any chance you may be pregnant? Y / N

Family History (Circle all that apply):

Bleeding problems / Anesthesia problems / Cancer / Stroke / Substance Abuse / Other: _____