

Medical History / Intake Form

Patient Information

Name _____ Date _____
 Email _____ Cell Phone _____
 Home Phone _____ Work Phone _____
 Street Address _____
 City _____ State _____ Zip _____
 Age _____ DOB _____ Occupation _____
 Name of party responsible for payment _____ Relation to Patient _____
 Emergency Contact(s) _____ Relation to Patient _____
 Emergency Contact Phone #s _____
 Who referred you? / How did you learn about Integrative Wellness? _____

Current Complaint(s)

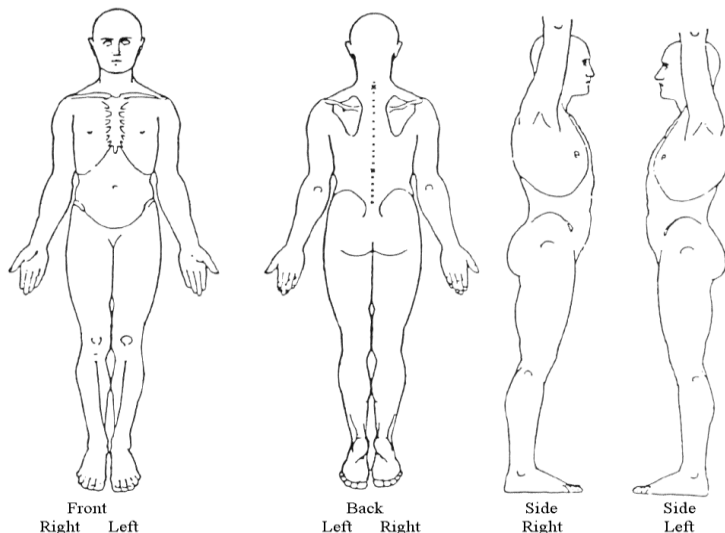
Briefly describe why you are seeking services. _____

Date that your symptoms started: _____ Are your symptoms work related? Yes ___ No ___
 Are your symptoms related to an accident? Yes ___ No ___ Date of accident: _____
 How, specifically, did your symptoms start? _____

Rate your symptoms (0 = no symptoms, 10 = absolute worst possible). Circle the # that applies.

On the average/most of the time:	0	1	2	3	4	5	6	7	8	9	10
At it's worst:	0	1	2	3	4	5	6	7	8	9	10
At it's best:	0	1	2	3	4	5	6	7	8	9	10
Goal range:	0	1	2	3	4	5	6	7	8	9	10

On the body diagram, please mark areas of your symptoms as they are at the time of your visit with an X or using a number from the 0-10 scale above.



What makes your symptoms worse? _____
 What makes your symptoms better? _____
 List any doctors you have seen for this condition: _____

 Are you pregnant? Yes ___ No ___

What treatment have you received for this issue? _____

Chiropractic/Osteopathic manipulation	Yes ___ No ___	Helpful? Yes ___ No ___
Trigger Point injections	Yes ___ No ___	Helpful? Yes ___ No ___
Epidural injections	Yes ___ No ___	Helpful? Yes ___ No ___
Physical Therapy	Yes ___ No ___	Helpful? Yes ___ No ___
Medications	Yes ___ No ___	Helpful? Yes ___ No ___
Acupuncture	Yes ___ No ___	Helpful? Yes ___ No ___
Other _____	Yes ___ No ___	Helpful? Yes ___ No ___

Medical History - Please submit separate typed or printed list(s) if necessary.

List any conditions for which you are currently being treated. _____

List any chronic or past conditions. _____

List any surgeries or traumatic injuries. _____

List any allergies including drug or food allergies. _____

How do you sleep? _____ How many hours? _____ How many interruptions? _____

Have you fallen in the last year? Yes ___ No ___ How many times? ___ Were you injured? Yes ___ No ___

List medication you are taking & the condition for which you are taking it. Include supplements.

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Do you have, or have you had: (please check if yes)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Cortisone Drug | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | Arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Arthritis (Osteo) | <input type="checkbox"/> Diabetic Ulcer | <input type="checkbox"/> Peripheral Artery | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Peripheral | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Disease | Neuropathy | |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Hypermobility | <input type="checkbox"/> Rheumatic Fever | |

Do you exercise regularly? Yes ___ No ___ If yes, explain how much, how often. Please describe frequency, duration, intensity and activity. _____

I certify that I have answered the above questions truthfully and correctly, to the best of my knowledge. I will notify you of any changes in my health status or the above information.

A copy of this document may be utilized the same as the original.

_____ Date: _____

Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:
