INTAKE & HEALTH HISTORY

PERSONAL INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Age: _____ **Date of Birth:** __/__/__ **Sex:** _____ **Gender:** _____ **Address:** _____

City/ State/ Zip: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Primary Care Provider: _____ **Insurance Provider:** _____

Occupation: _____ **Employer:** _____

Emergency Contact Name: _____ **Emergency Contact Number:** _____

How did you hear about us: _____

_____

REASON FOR SEEKING CARE

What are your complaints (in order of severity): _____

_____

When did this begin? _____

How did your symptoms begin? _____

How often do you experience symptoms? _____

What makes your complaints better/worse? _____

_____

Have you seen another provider for this complaint? _____

Have you tried anything to relieve the symptoms? _____

_____

On a scale from 1 to 10, with 10 being the worst, how would you rank your complaint today? _____

This form is only a preliminary questionnaire, and the doctor will have more questions during your visit. However, if there is any additional information you would like to add regarding your complaint, please use the space provided here: _____

_____

HEALTH HISTORY

Please circle the boxes if you have or have had any of the listed conditions:

Musculoskeletal	**Cardiovascular**	**Endocrine**	**Respiratory**
Arthritis	High Blood Pressure	Thyroid Issues	Asthma
Osteoporosis	High Cholesterol	Immune Disorders	Apnea
Scoliosis	Poor Circulation	Diabetes	Emphysema
Neck Pain	Angina	Frequent Infections	Difficulty Breathing
Back Problems	Excessive Bruising	Low Energy	Pneumonia
Hip Dysfunction	Cardiac Dysfunction	Addison's Disease	Chronic Bronchitis
Knee Injuries	Other:	Other:	Other:
Elbow/Wrist Pain			
TMJ Dysfunction	**Digestive**	**Genitourinary**	**Integumentary**
Foot/Ankle Pain	Anorexia/Bulimia	Kidney Stones	Skin Cancer
Shoulder Problems	Ulcer	Prostate Issues	Psoriasis
Herniated Discs	Food Sensitivities	Recurrent Infections	Eczema
Sprained Joints	Crohn's Disease	Infertility	Rash
If severe, specify:	Ulcerative Colitis	Menstrual Issues	Other:
	Constipation	Frequent Urination	
Strained Muscles	Diarrhea	Difficulty with Urination	
If severe, specify:	Other:	Other:	
Fractured Bones:	**Sensory**	**Constitutional**	**Neurological**
If severe, specify:	Blurred Vision	Fainting	Anxiety
	Ringing in the Ears	Weakness	Depression
Other:	Hearing Loss	Fatigue	Headaches
	Loss of Smell	Low Appetite	Dizziness
	Loss of Taste	Low Libido	Numbness
	Chronic Ear Infections	Altered Mood	Tingling
	Other:	Other:	Other:

Please explain any items circled above:

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Are there any past or current medical conditions we didn't ask you about?

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Condition: _____ Explanation: _____

Please list any past hospitalizations:

Date: _____ Procedure/Reason: _____

Date: _____ Procedure/Reason: _____

Date: _____ Procedure/Reason: _____

Date: _____ Procedure/Reason: _____

Date: _____ Procedure/Reason: _____

Please list any other injuries or accidents not listed above:

Date: _____ Injury/Accident: _____

Date: _____ Injury/Accident: _____

Date: _____ Injury/Accident: _____

Date: _____ Injury/Accident: _____

Date: _____ Injury/Accident: _____

Please use this space to elaborate on any condition, hospitalization, injury or accident if the space provided was not sufficient: _____

_____

Please list all prescriptions, over the counter medicines, and supplements:

Medication/Supplement: _____ Dosage/Frequency: _____

Medication/Supplement: _____ Dosage/Frequency: _____

Medication/Supplement: _____ Dosage/Frequency: _____

Medication/Supplement: _____ Dosage/Frequency: _____

Medication/Supplement: _____ Dosage/Frequency: _____

Medication/Supplement: _____ Dosage/Frequency: _____

Medication/Supplement: _____ Dosage/Frequency: _____

Please list any diagnosed medical conditions within your immediate family:

Mother: _____

Father: _____

Siblings: _____

Children: _____

Grandparents: _____

Please provide information regarding your current lifestyle:

Please list any allergies you are aware of: _____

Do you, or have you, used tobacco of any type: _____

Do you use recreational drugs, what kind, and how frequently: _____

Do you consume alcohol, and how frequently: _____

Do you consume coffee, and how frequently: _____

Do you consume soda, and how frequently: _____

How much water do you drink on a daily basis: _____

Do you exercise, and how frequently: _____

How many hours of sleep do you get each night: _____

What position do you sleep in: _____

On a scale of 1 to 10, 10 being the best, how healthy are your eating habits: _____

On a scale of 1 to 10, 10 being the worst, how much stress do you have: _____

What are your current goals related to personal health: _____

Verifications & Agreements

Please review the following statements and sign on the last line indicating your agreement:

General Verification: To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern, and the practicioner is not liable for omissions in my own health history.

Payment Verification: I acknowledge that any insurance I may have is an agreement between the carrier any myself, and that I am ultimately responsible for the payment of any covered or non-covered services I receive.

Signature: _____ **Date:** _____