Patient Intake Form

For Office Use Only

Date: ______________________

Acct #:______________________

Patient Height ______________

Patient Weight ______________

Patient BMI _______________

Patient Blood Pressure _______

First Name: ___________________________________Middle Initial_________

Last Name: __________________________________

Street Address ____

Mailing Address ____

City__________________________ State _________ Zip code _______________

Home Phone ___________________________ Work Phone _______________________

Cell Phone ____________________________ Marital Status ___Single___ Married

As a courtesy to our patients we provide an automated reminder call. How would you like to be contacted?

___ Home Phone ___ Cell Phone ___ Text Message ___E-mail.

Date of Birth ______________________ Age ___________ Social Security Number _________________________________

Sex ___ Male ___ Female ___ Other Preferred Language _____________________________

Race (circle only 1)

- American Indian
- Asian
- Black or African American
- Native Hawaiian
- Alaska Native
- White
- Other Pacific Islander
- Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino Not Hispanic or Latino

** Please provide proof of insurance, via card or a letter from your insurance company to the front desk person along with your drivers license or ID card.

Thank you.

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ______________________________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____________________________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ________________

Briefly describe the accident, injury or illness:____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies: ____

❑Medications: ____

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________Transported by? ❑Ambulance ❑Police ❑Other: ____________________

Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________

List the hospital procedures received: ____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________________ To: ____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ______________________________

What type of work do you do?____

____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ____________________

____

List any past conditions you may have had: ____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker
❑Former Smoker ❑Never Smoker
❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _______
❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _______

EXERCISE

❑None
❑Moderate
❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: ____________________________
Route: Oral
Intravenous
Other: ____________________
Frequency: ____________________
Began Use: ____________________
Discontinued Use: ____________________

Medication: ____________________________
Route: Oral
Intravenous
Other: ____________________
Frequency: ____________________
Began Use: ____________________
Discontinued Use: ____________________

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: ______________________________

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: ____________________________
Reaction: ____________________________
Start Date: ____________________________
End Date: ____________________________

Allergy: ____________________________
Reaction: ____________________________
Start Date: ____________________________
End Date: ____________________________

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

Notice: Patient Privacy

We are committed to preserving the privacy of your personal health information. In Fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and related administrative activities supporting you treatment.

We may be required or permitted by certain laws to use and or disclose or your medical information for other purposes with out your consent or authorization. We are required to inform you that your insurance claims may be sent via electronic billing services. We have available to you a detailed NOTICE OF PRICVACY PRACTICES that fully explains your rights and our obligations under the law. You have the right to obtain a copy of the most current NOTICE by asking for one at the front desk.

NOTE:

I have been advised of the PRIVACY PRACTICES FOR HEALTH WITHIN WELLNESS CENTER.

Patient/Client Initials_____

Consent to Care Form

I _____, a patient or client to one or more of the providers for Health Within Wellness Center give him or her permission and authority to care for me. I understand and agree that all procedures, diagnosis and analysis stay within that providers scope of practice and licensure. I understand that the clinical procedures preformed are usually beneficial and seldom cause any problems. However, in rare cases underlying physical defects, deformities, or pathologies, may render me susceptible for further injury. The provider, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated.

It is my responsibility as a patient or client to make the provider aware of any known physical defects, deformities, or illnesses that I am aware of; or any that I become aware of during the coarse of my treatment.

- I understand that chiropractic does not offer to diagnose or treat any disease or condition other that the vertebral subluxation.
- I understand and agree that Massage Therapy Providers can not diagnose or Prescribe.
- I recognize there are potential risks and benefits form Acupuncture procedures as described below:

Potential Benefits: of treatment include relief from pain and illness and improved overall feeling of health and well-being.

Potential Risks: There is a potential for acupuncture to produce some discomfort, pain, minor bruising, temporary discoloration or infection. Clients with severe bleeding disorders or pacemakers should inform their practitioner prior to treatment. Herbal clients should inform their practitioner of any allergies they might have.

Patient's/Guardian's Signature: _____ Date: _____