New Patient Intake Form

Patient Data

Name: _____ Date of Birth_____

Address:_____ City: _____ State: _____

Zip: _____ Home #: _____ Cell # _____

SS#_____ E-Mail: _____

Preferred Contact? _____ Employer _____ Gender: M F

Marriage Status: _____ # of Children: _____ Ages: _____

Emergency Contact: _____ Phone # _____

☐ I want to receive appoint reminders via text message *Carrier? _____
☐ I want to receive appointment reminders via email?
☐ I want to receive information and announcements via email?
* Standard rates/fees from carriers may apply

Whom may thank for referring you? _____

Guarantors Information (person carrying insurance): _____

Relationship: _____ Date of Birth: _____ Phone #_____

Address (if different): _____

What brings you to our office: ☐ Automobile Accident ☐ Non- Accident/Trauma ☐ Injury
☐ Wellness Care

(Please fill out the sections corresponding to your type of case for injury and automobile)

Automobile Accident or Injury: (please circle where appropriate)

When did it occur? _____ Immediately after the accident, did you feel dazed? Yes No

Did you lose consciousness? Yes No Was your head injured? Yes No

Immediately after the accident, did you experience: Headaches Neck Pain Low back pain

Did you see another doctor before coming here? Yes No If yes, name of doctor: _____

Did you go to a hospital after the accident/injury? Yes No If yes, which hospital? _____

How did you get to the hospital? Ambulance Drove Self Somebody else Police

Were any of the following test performed at the hospital? X-rays MRI CT Labs

Did the injury occur on the job? Yes No Was it reported? Yes No

Automobile (only)

What was your position in the vehicle? Driver Front Passenger Rear Passenger

What was the damage to the vehicle? Mild Moderate Extensive Totals

What was the visibility on the road? Poor Fair

And the weather was: Clear Raining Windy Foggy Snowing

How did the accident happen? I hit another vehicle Another vehicle hit me I hit an object

The point of impact on your vehicle was? (please describe):

_____

Did you see the accident coming? Yes No Were you braced for the impact? Yes No

Where you wearing a seatbelt? Yes No Does your vehicle have an airbag? Yes No

Did the airbag deploy? Yes No Does your vehicle have headrest? Yes No

What was the position of the headrest?

Even with top of head Even with bottom of head Middle of neck

Did you strike anything inside the vehicle? Yes No If yes, what? _____

Which way was your head turned during the accident? Straight Turned Right Turned Left

All cases (automobile, non-accident/trauma, injury and wellness care) (please circle)

Do you feel your condition / health is: Improving Staying the same Getting worse

Have you lost time from work? Yes No Can you perform physical work activities? Yes No

If no, because of: Pain Weakness Stress Can you sleep without problems? Yes No

Do you awaken because of pain? Yes No Did you have sleep problems before? Yes No

Activates of Daily Living Please select all activates which you are currently experiencing problems:

Seeing	Tasting	Smelling	Eating	Hearing	Insomnia
Dressing	Reading	Typing	Writing	Grasping	Using the toilet
Standing	Leaning	Walking	Stooping	Squatting	Loss of sexual drive
Bending	Twisting	Carrying	Lifting	Pushing	Restful sleeping
Sitting	Driving	Sports	Exercising	Reclining	Loss of concentration
Irritable	Riding in car	Air travel	Climbing	Pulling	Changes in personality
Grooming	Pinching	Kneeling	Reaching	Nervous	Tactile feeling

Past Medical History (Please circle all conditions that you have had or are currently having)

Abdominal pain	Weight gain/loss	Angina	Anorexia	Anxiety
Arthritis	Aortic aneurysm	Asthma	Bladder infection	Blood disorder
Breast Lumps	Breast soreness	Bronchitis	Cancer	Cardiovascular
Chest Pain	Chronic cough	Chronic sinusitis	Colitis	Constipation
Convulsions	COPD	Depression	Dermatitis	Diabetes
Difficulty in swallowing	Dizziness	Emphysema	Endometriosis	Epilepsy
Excessive thirst	Fainting	Frequent urination	General fatigue	Gout
Hand pain	Headache	Heart attack	Heart disease	
Heartburn/Indigestion	Hepatitis	High Blood pressure	High Cholesterol	High PSA
High triglycerides	Hypertension	Irregular menstrual flow	Irritable colon	Jaw pain
Kidney disorders	Kidney stones	Liver/Gallbladder	Loss of appetite	Bladder control
Low back pain	Lung disease	Mental disease	Mid back pain	Neck pain
Muscular incoordination	Osteoarthritis	Foot/ankle pain	Knee pain	Leg/Hip Pain
Arm/elbow pain	Painful urination	Pneumonia	Profuse menstrual flow	PMS
Prostate problems	Rapid heartbeat	Renal disease	Rheumatoid arthritis	Scoliosis
Shoulder pain	Stroke	Swelling/stiff joints	Thyroid disease	Tinnitus
Tuberculosis	Tumor	Ulcer	Visual disturbances	Wrist pain

Other: _____

Surgical History (please circle all surgeries you have had in the past)

Abdominal exploration	Abdominoplasty	Abortion	ACL reconstruction
Adenoid removal	Angioplasty	Appendectomy	Bone fracture repair
Breast lump	Bunion removal	Carotid artery surgery	Cataract surgery
Cervical spine surgery	Cholecystectomy	Cosmetic breast	C-Section
Facelift	Gallbladder Removal	Gastric Bypass	Heart Bypass
Heart Surgery	Hemorrhoid	Hernia Repair	Hip Joint Replacement
Hysterectomy	Kidney Transplant	Knee Arthroscopy	Knee Replacement
LASIK eye	Liposuction	Lumbar Spine	Mastectomy
Prostate Removal	Rotator Cuff	TMJ	Tonsillectomy

Vasectomy Other: _____

Family History: (please circle all conditions that run in your family)

Abdominal pain	Weight gain/loss	Angina	Anorexia	Anxiety
Arthritis	Aortic aneurysm	Asthma	Bladder infection	Blood disorder
Breast Lumps	Breast soreness	Bronchitis	Cancer	Cardiovascular
Chest Pain	Chronic cough	Chronic sinusitis	Colitis	Constipation
Convulsions	COPD	Depression	Dermatitis	Diabetes
Difficulty in swallowing	Dizziness	Emphysema	Endometriosis	Epilepsy
Excessive thirst	Fainting	Frequent urination	General fatigue	Gout
Hand pain	Headache	Heart attack	Heart disease	
Heartburn/Indigestion	Hepatitis	High Blood pressure	High Cholesterol	High PSA
High triglycerides	Hypertension	Irregular menstrual flow	Irritable colon	Jaw pain
Kidney disorders	Kidney stones	Liver/Gallbladder	Loss of appetite	Bladder control
Low back pain	Lung disease	Mental disease	Mid back pain	Neck pain
Muscular incoordination	Osteoarthritis	Foot/ankle pain	Knee pain	Leg/Hip Pain
Arm/elbow pain	Painful urination	Pneumonia	Profuse menstrual flow	PMS
Prostate problems	Rapid heartbeat	Renal disease	Rheumatoid arthritis	Scoliosis
Shoulder pain	Stroke	Swelling/stiff joints	Thyroid disease	Tinnitus
Tuberculosis	Tumor	Ulcer	Visual disturbances	Wrist pain

Other: _____

Social History: (please circle appropriate responses)

Do you currently use alcohol? Yes No If yes, type and amount per week: _____

Do you currently use tobacco? Yes No If yes, type and amount per week: _____

Do you use other recreational drugs? Yes No If yes, type and amount: _____

Are you a former smoker? Yes No Date Stopped: _____

Do you exercise? Yes No If yes, type and amount per week: _____

Have you been abused? Yes No Are you currently being abused? Yes No

Allergies: (please circle all items that you are allergic to)

Chemical Environmental Food Seasonal Other

Medications (what? _____)

Medications / Supplements (please list with dosage)

_____ _____

_____ _____

_____ _____

_____ _____

Chief Complaint

Please list your complaints/concerns in order of importance to you:

1.) _____

2.) _____

3.) _____

4.) _____

Complaint # 1 (Please circle all that apply)

This complaint came on: Gradually Immediately Is it getting: Better Same Worse

The intensity of this complain is: Minimal Slight Moderate Severe

The frequency of this complaint is: Occasional Frequent Constant

The Pain is: Dull Sharp Aching Shooting Spasm

Throbbing Shooting Tingling

The pain is located on the: Left Side Right Side Both Sides

Please grade your pain 0-10 (0 being no pain, 10 being the worse pain you have had): _____

Actions that Aggravate this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Actions that Relieves this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Your biggest concern with is problem is: _____

Complaint # 2 (Please circle all that apply)

This complaint came on: Gradually Immediately Is it getting: Better Same Worse

The intensity of this complain is: Minimal Slight Moderate Severe

The frequency of this complaint is: Occasional Frequent Constant

The Pain is: Dull Sharp Aching Shooting Spasm

Throbbing Shooting Tingling

The pain is located on the: Left Side Right Side Both Sides

Please grade your pain 0-10 (0 being no pain, 10 being the worse pain you have had): _____

Actions that Aggravate this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Actions that Relieves this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Your biggest concern with is problem is: _____

Complaint # 3 (Please circle all that apply)

This complaint came on: Gradually Immediately Is it getting: Better Same Worse

The intensity of this complain is: Minimal Slight Moderate Severe

The frequency of this complaint is: Occasional Frequent Constant

The Pain is: Dull Sharp Aching Shooting Spasm

Throbbing Shooting Tingling

The pain is located on the: Left Side Right Side Both Sides

Please grade your pain 0-10 (0 being no pain, 10 being the worse pain you have had): _____

Actions that Aggravate this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Actions that Relieves this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Your biggest concern with is problem is: _____

Complaint # 4 (Please circle all that apply)

This complaint came on: Gradually Immediately Is it getting: Better Same Worse

The intensity of this complain is: Minimal Slight Moderate Severe

The frequency of this complaint is: Occasional Frequent Constant

The Pain is: Dull Sharp Aching Shooting Spasm

Throbbing Shooting Tingling

The pain is located on the: Left Side Right Side Both Sides

Please grade your pain 0-10 (0 being no pain, 10 being the worse pain you have had): _____

Actions that Aggravate this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Actions that Relieves this complaint are:

Morning	Afternoon	Cold	Heat	Medication
Straining	Standing	Sitting	Lying down	Bending forward
Bending back	Bending left	Bending right	Twisting right	Twisting left
Lifting	Coughing	Sneezing		

Your biggest concern with is problem is: _____