NEW PATIENT INTAKE FORM

DATE: ___________________

DEMOGRAPHICS

NAME: ____

BIRTHDAY: ___________________

EMAIL: ____

PHONE NUMBER: ___________________

ADDRESS: ____

REFERRAL SOURCE: ______________________________________

PRIMARY CARE PHYSICIAN: ______________________________________

ADDRESS: ____

PHONE: ___________________

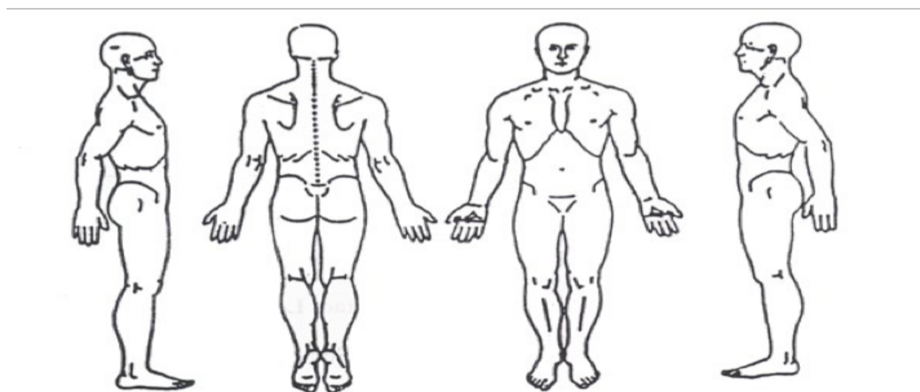
HAVE YOU SEEN THIS PHYSICIAN FOR YOUR CURRENT COMPLAINT?
- ☐ NO
- ☐ YES, WHEN: ______________________________________

ARE YOU SEEKING ANY OTHER TREATMENT FOR YOUR CURRENT COMPLAINT?
- ☐ NO
- ☐ YES, EXPLAIN: ______________________________________

PARENT/GUARDIAN INFORMATION (IF PARTICIPANT IS UNDER 18)
NAME: ____
RELATION TO PARTICIPANT: ___________________
PHONE NUMBER: ___________________

CURRENT COMPLAINT

—> MARK THE FOLLOWING USING AN (X) FOR PAIN AND (~) FOR NUMBNESS/TINGLING



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NEW PATIENT INTAKE FORM

MEDICAL HISTORY

—> MARK AN (X) BY ALL CURRENT CONDITIONS AND (P) FOR PAST CONDITIONS

__ Abdominal/Digestive Problems
__ Allergies
__ Anxiety
__ Arthritis/Tendonitis
__ Asthma/Breathing Conditions
__ Athletes Foot
__ Blood Clots
__ Bowel/Bladder Issues
__ Cancer
__ Chronic Pain
__ Circulatory/Heart Problems
__ Constipation/Diarrhea
__ Depression
__ Diabetes
__ Fatigue
__ Headaches/Migranes
__ Hearing Problems
__ Heart Attack
__ Hernia
__ High Blood Pressure
__ Jaw Pain/TMJ
__ Low Blood Pressure
__ Muscle/Bone Injuries
__ Numbness/Tingling
__ Night Pain
__ Pregnancy
__ Rash/Fungus
__ Seizure
__ Sinus Problems
__ Sleep Difficulties
__ Spinal Disorders
__ Sprain/Strain
__ Stroke
__ Tension/Stress
__ Varicose Veins
__ Vision Problems
__ Weight Loss (Unintentional or Excessive)
__ Other: ____________________

LIST ANY RECENT INJURIES OR SURGERIES WITHIN THE PAST 5 YEARS:

____
____
____
____

LIST ANY PRESCRIBED MEDICATION OR SUPPLEMENTS YOU ARE TAKING:

____
____
____
____

LIST ANY OTHER PERTINENT INFORMATION REGARDING YOUR MEDICAL HISTORY:

____
____
____
____

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