

Confidential Health Intake Form

Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Home phone \_\_\_\_\_ Cell Phone/pager \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Was Injury a result of an accident? \_\_\_\_\_ If yes: Job related \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_

Date of Injury or onset: \_\_\_\_\_

Medical History and Information

Check any or all that apply to your present health:

- headaches
- chronic pain
- varicose veins
- stiffness
- muscle or joint pain
- blood clots
- vision problems
- numbness/tingling
- high/low blood pressure
- sinus problems
- sprains/strains
- diabetes
- jaw pain/teeth grinding
- scoliosis
- cancer/tumors
- fatigue
- arthritis
- infectious disease
- depression
- tendonitis
- skin problems
- sleep difficulties

Women only:  Pregnant  Painful menstruation  endometriosis

List all medications/herbs/vitamins and dosage: \_\_\_\_\_

List physical activities you participate in regularly \_\_\_\_\_

What movement or activities are limited? \_\_\_\_\_

Describe the events of the injury or accident: \_\_\_\_\_

List previous major injuries/surgeries: \_\_\_\_\_

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): \_\_\_\_\_

What seems to help the most? \_\_\_\_\_

What seems to aggravate the condition the most? \_\_\_\_\_

What is your main activity at work?  On phone  Sitting  Computer work  
 Driving car  Walking  Other \_\_\_\_\_

What do you do to relieve stress? \_\_\_\_\_

\*\*What do you want to get out of you session (s)? \_\_\_\_\_

Practitioner Comments \_\_\_\_\_

\_\_\_\_\_

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