



REGISTRATION & HISTORY

Date _____

Welcome to our office!

Please fill out this Confidential Client Intake Form as **thoroughly** as possible.

CLIENT INFORMATION

Client _____
 Address _____

 City State Zip
 Primary Phone (Home/Work/Cell) _____
 Secondary Phone (Home/Work/Cell) _____
 Best time and number to reach you at _____
 Sex: M F Age ____ Date of Birth _____
 Single Married Other
 Client SS# _____
 Email _____
 Employer _____
 Employer Address _____

 City State Zip
 Employer Phone _____ ext. _____
 Occupation _____
 Number of hours worked per week _____
 How did you hear about us? _____

IN CASE OF EMERGENCY, CONTACT

Name _____
 Relationship _____
 Phone _____

PRIMARY CARE PHYSICIAN

Name _____
 Address _____

 Phone _____ Fax _____
 Date Last Seen _____

ACCIDENT INFORMATION Complete if injury is due to an accident

Is client injury related to:
 employment auto accident State _____
 other accident crime (Only for Medicaid)
 Attorney Name (if applicable) _____
 Address _____

INSURANCE Complete if you want to submit for reimbursement

We are sorry for any inconvenience however we do not accept Medicare Clients.

Who is the **Primary Card Holder**? _____
 Relationship to client _____
 Address (if different from client) _____

 City State Zip
 Phone number (if different from client) _____
 Date of Birth of Primary Card Holder _____
 ID Number _____ Group # _____
 Insurance Co. _____

Is client covered by additional insurance? Yes No

Who is the **Secondary Card Holder**? _____
 Relationship to client _____
 Address (if different from client) _____

 City State Zip
 Phone number (if different from client) _____
 Date of Birth of Secondary Card Holder _____
 ID Number _____ Group # _____
 Insurance Co. _____

Client is financially responsible for all charges whether or not reimbursed by insurance.

MEDICATIONS

VITAMINS / HERBS / SUPPLEMENTS

ALLERGIES

CLIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____ How did this happen? _____

Is this condition progressively getting worse? Yes No Unknown

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down Other _____

What treatment have you already received for your condition? Medical PT Chiropractic None Other _____

Name of other doctor(s) who have treated you for your condition _____

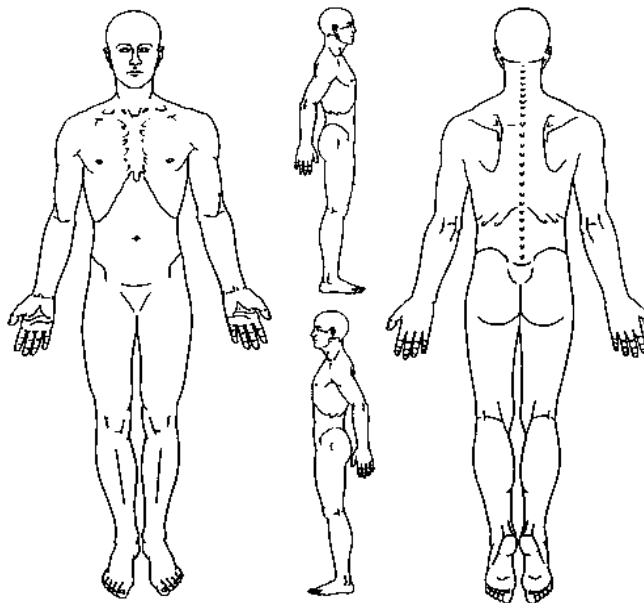
Suspected or known diagnosis of your condition _____

PAIN ASSESSMENT
Type of Pain

- Sharp
- Dull
- Throbbing
- Aching
- Shooting
- Cramps
- Stiffness
- Swelling
- Numbness
- Burning
- Tingling
- Pressure
- Other _____

Pain Diagram

On the diagram below, please indicate where you are experiencing pain or other symptoms right now.


Pain Scale

Please rate the severity of your pain on a scale from 0 to 10

Worst pain imaginable

- 10
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1
- 0

No pain

GOALS

What are your goals for coming here _____

PAST INJURIES / SURGERIES

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Joint Replacements	_____	_____

Get Well Naturally . . . Live to Your Potential

EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____

HEALTH HISTORY			
Have you had any of the following in the past 6 months or is a chronic issue:			
AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Bloating <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No Depression/Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/COPD <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Gas <input type="checkbox"/> Yes <input type="checkbox"/> No Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No Gout <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches/Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Irritability <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Measles <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Nervousness <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No Polio <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in Ears <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus/Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Tract Infection <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Weight Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ _____ Are you pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Due Date _____

FAMILY HISTORY (Check all those that apply)									
	Father	Mother	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother	Brother(s) / Sister(s)	Spouse	Children
Age (or Age at death)									
Health (G=good, F=fair, P=poor)									
Cause of Death									
Arthritis									
Asthma									
Back Problems									
Cancer									
Circulatory Problems									
Diabetes									
Emphysema / COPD									
Headaches									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Osteoporosis									
Sinus Problems / Allergies									
Stroke									
Thyroid Problems									
Ulcer or Stomach Problems									
Other									

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