



# 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  
 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 \_\_\_\_\_

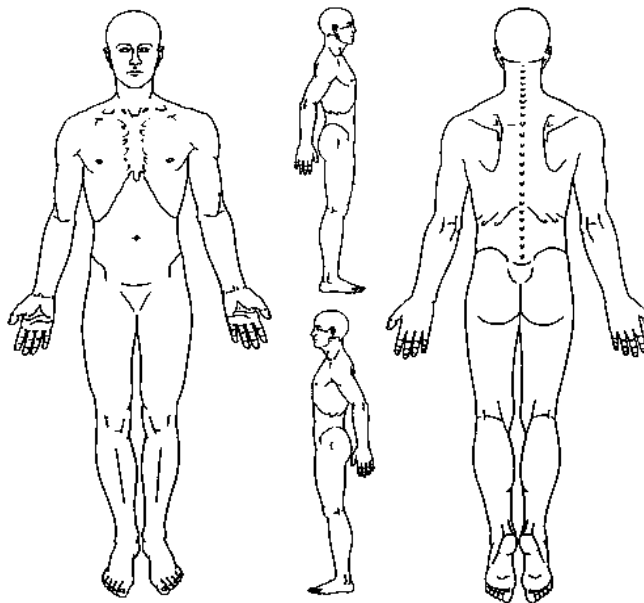
Suspected or known diagnosis of your condition \_\_\_\_\_

**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	_____	_____

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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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