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New Patient Intake Form

Basic Patient Information

Name: _____ Date: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Sex: M F Age: _____ Birth date: _____
How tall are you? _____ How much do you weigh? _____
How did you hear about us? _____
Education: ____ High School _____Advanced Degree/Vocational Degree ____College Graduate
Marital Status: Single Married Widowed Separated Divorced
If married, please give spouse's occupation: _____
Number of kids? _____
Current Occupation or Last Job: _____
Current Employment Status: ____Full Time _____Part Time _____Unemployed
____Homemaker _____Retired _____Student

Health and Wellness History

Primary Care Physician: _____ Referring Physician: _____
Treating what conditions? _____
Medical Prescriptions: _____
Over-the-Counter Medications: _____
Vitamins/Minerals: _____
Herbs: _____
Family History: _____
Previous Illnesses: _____
Known Allergies/Sensitivities: _____
Surgeries: _____
Accidents: _____

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you once you become a patient, and you are personally responsible for payment. This office does not accept insurance of any kind. The services provided are not covered by insurance due to the natural, alternative approach we use here. Your signature also indicates that you authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

Signature: _____ Date: _____

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Pain and Neuropathy Concerns (Part 1)

Please answer the following questions honestly so we can do our best to help you reach your goals.

Is your pain or numbness the result of an accident? ( ) Yes ( ) No
If yes, where did it occur? Circle one: Home Work Vacation Car Other
Describe what happened: _____
_____
_____
Are you receiving compensation or disability payments now? ( ) Yes ( ) No
If yes, are the payments adequate? ( ) Yes ( ) No
Do you have an application for compensation or disability payments pending? ( ) Yes ( ) No

What is the main problem for which you are seeking treatment at our clinic?
_____
_____
Please describe the location of your pain and numbness:
_____
_____
How long have you had your current pain or numbness problem?
_____
_____
How did your current pain or numbness start? Was there a precipitating event?
_____
_____

How do the following affect your pain, numbness or tingling? *(Please circle one for each item.)*

Lying Down	Decrease	No Effect	Increase
Standing	Decrease	No Effect	Increase
Sitting	Decrease	No Effect	Increase
Walking	Decrease	No Effect	Increase
Exercise	Decrease	No Effect	Increase
Medication	Decrease	No Effect	Increase

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Pain and Neuropathy Concerns (Part 2)

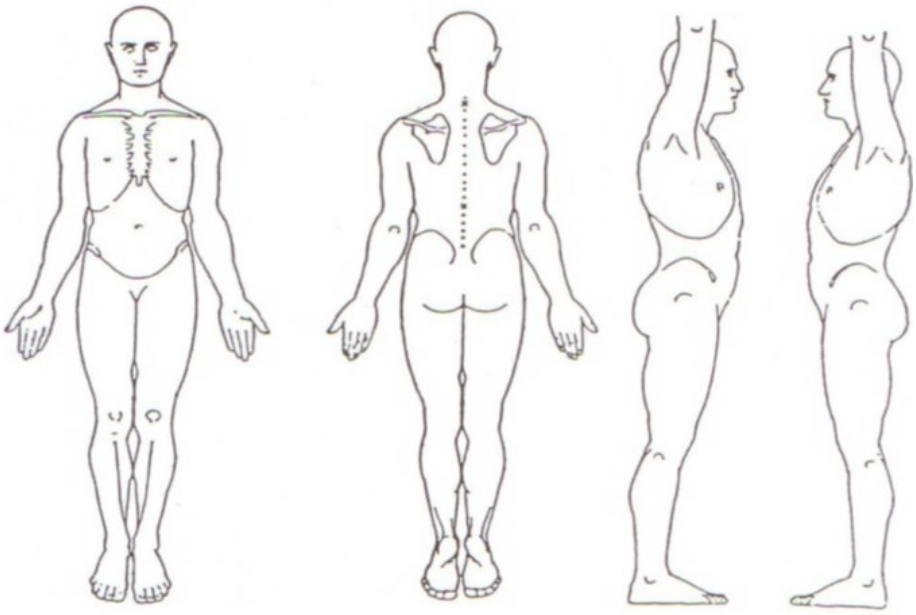
Please answer the following questions honestly so we can do our best to help you reach your goals.

Please circle all of the treatments you have tried for your pain, numbness or tingling:

Hospital bed rest	Traction	Surgery	Exercise
Nerve block or injection	TENS (electrical stimulator)		Physical Therapy
Psychotherapy			

Which ones helped you the most? _____
Which ones helped you the least? _____

Have you ever been in treatment for misuse of alcohol or drugs? ____Y ____N
If yes, where and when?_____



Mark the areas that you are experiencing your pain, numbness or tingling. Indicate your pain or numbness type by marking with a letter or letters.

a) deep (inside)
b) superficial (on the skin)
c) constant (all the time)
d) intermittent (starts and stops)
e) aching
f) burning
g) shooting

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Pain and Neuropathy Concerns (Part 3)

Please answer the following questions honestly so we can do our best to help you reach your goals.

Are there other factors that make your pain, numbness or tingling

Better?_____

Worse?_____

Please rate your pain, numbness or tingling intensity on a scale from 0 (no pain) to 10 (excruciating, incapacitating, worst possible). Rate your pain, numbness or tingling during the past month.

Your pain, numbness at its worst _____
Your pain, numbness at its least _____
Your average pain, numbness_____
Your current pain, numbness _____

How often do you have your pain, numbness or tingling?

_____Constantly (100% of the time) _____Nearly constantly (60-95% of time)
_____Intermittently (30-60% of time) _____Occasionally (less than 30% of time)

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ( ) Yes ( ) No
If yes, what and when?

_____

_____

.....

Office Use Only:

_____

_____

_____

_____

History:

_____

_____

_____

_____

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Frequency of Purchase

Please circle the average number of times daily OR the average number of times weekly you purchase these items.

Soda	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Cup of Brewed Coffee	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Cup of Specialty Coffee	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Small Bag of Chips	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Candy Bar	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Pack of Gum	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Alcoholic Beverage	Circle **ONLY** one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Eating Out/Lunch	Circle ONLY one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____
Eating Out/Dinner	Circle ONLY one for either day or week: Times Per **DAY**: 1 2 3 4 5 6 7 8 9 10 Or Times Per **WEEK**: 1 2 3 4 5 6 Or per **MONTH**: _____