New Member Intake

General Information:

Patient Name _____ Date _____

Date of Birth _____ Occupation _____

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive: Emails: Yes No Texts: Yes No Mail: Yes No

Emergency Contact _____ Relationship _____ Phone # _____

Focus

What is the primary reason for seeking care? _____

What was the initial cause? _____

When did it begin? _____

What makes it better? _____

What makes it worse? _____

How does this problem interfere with your daily activities?

☐ Work	☐ Standing	☐ Sexually	☐ Driving
☐ Sleep	☐ Emotional	☐ Recreation	☐ Exercise
☐ Walking	☐ Relationships	☐ Bending	
☐ Sitting	☐ Social Life	☐ Stretching	

☐ Other_____

What have you already done about this? _____

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): _____

On a scale of 1-10, how committed are you to correcting your issue? _____

Medical History

List your allergies: _____

List your medications: _____

List your supplements: _____

_____

Describe your sleep: _____

Please indicate if you have or have had any of the following:

☐ Hepatitis ☐ HIV/AIDS ☐ Diabetes I or II ☐ Anemia ☐ Cancer: Type _____

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of _____	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other:
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

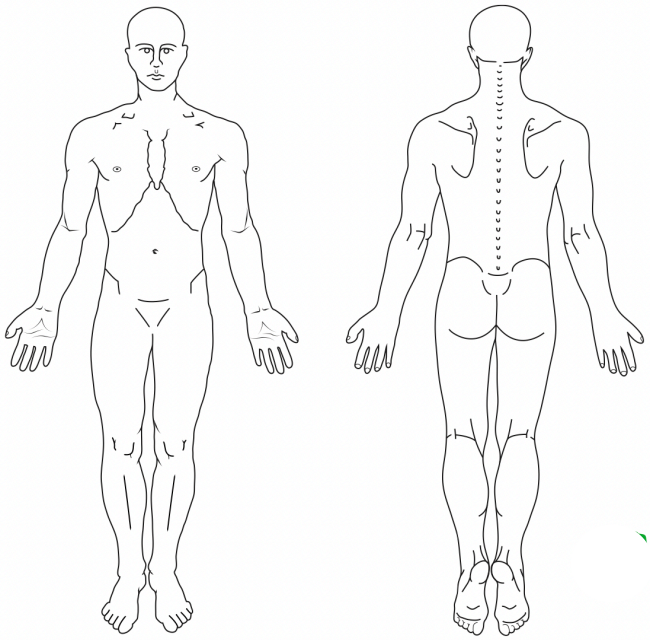
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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