New Patient Intake Form

Please fill out the form in as much detail as possible.

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Patient information

Name _____ Date _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ Work _____

Age _____ Date of birth _____ Social Security # _____ Sex: ☐ M ☐ F

Occupation _____ Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Health insurance _____ ☐ PPO ☐ EPO ☐ HMO

Referred by _____ Height _____ Weight _____

E-mail address _____

Emergency contact _____ Relationship _____ Phone _____

Your problem

Primary problem _____

Date of injury/onset _____

How did it happen? _____

What makes it worse? _____

What makes it better? _____

Rate your problem (1 = no pain, 10 = unbearable): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the problem getting worse? ☐ No ☐ Yes If yes, explain: _____

Describe how the pain feels (sharp, dull, achy, shock-like, burning, etc.): _____

Does the problem radiate into the arms/legs? ☐ No ☐ Yes Where: _____

At what time of day is the problem worse? ☐ Constant ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Have you ever had a similar problem before? ☐ No ☐ Yes When: _____

Are you taking any medication for this problem? ☐ No ☐ Yes List: _____

Health history

Please check No or Yes for each of the following:

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes
Recent infection	☐	☐	Headaches	☐	☐	Cancer/tumor _____	☐	☐
Recent fever	☐	☐	Jaw pain ☐ Left ☐ Right	☐	☐	Recent frequent urination	☐	☐
HIV / AIDS	☐	☐	Neck pain	☐	☐	Recent urinary retention	☐	☐
Diabetes	☐	☐	Upper back pain	☐	☐	Birth control pills	☐	☐
High blood pressure	☐	☐	Lower back pain	☐	☐	Pregnancy _____	☐	☐
Epilepsy / seizures	☐	☐	Shoulder pain ☐ Left ☐ Right	☐	☐	Numbness in the groin/buttocks	☐	☐
Dizziness / fainting	☐	☐	Elbow pain ☐ Left ☐ Right	☐	☐	Prostate problems	☐	☐
Visual disturbance	☐	☐	Wrist/hand pain ☐ Left ☐ Right	☐	☐	Stroke _____	☐	☐
Osteoporosis	☐	☐	Hip pain ☐ Left ☐ Right	☐	☐	Alcohol use _____	☐	☐
Corticosteroid use	☐	☐	Knee pain ☐ Left ☐ Right	☐	☐	Tobacco use _____	☐	☐
Arthritis	☐	☐	Ankle pain ☐ Left ☐ Right	☐	☐	Surgeries _____	☐	☐
Aortic aneurysm	☐	☐	Foot pain ☐ Left ☐ Right	☐	☐	Medications _____	☐	☐

Family history: ☐ Arthritis ☐ High blood pressure ☐ Cancer ☐ Diabetes ☐ Heart problems

Certification

I certify that the above information is true and accurate. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due and payable.

Patient's signature _____ Date _____

If you need this form in another format or help completing it, call (818) 518-6204.