

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Sharing of My Patient Record: My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ male female

Address: _____

Marital status

S	M	W	D	SEP
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Phone #: home: _____ work: _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Mark (c) for current problems, check and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
 - Bladder infection
 - Blood in urine
 - Kidney infection
 - Kidney stones
 - Prostate trouble
 - Pus in urine
 - Stress incontinence
- Urination
- Overnight more than twice
 - More than 8x in 24hrs
 - Decreased flow/force
 - Painful urination
 - Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

Menstrual flow

- Reg. Irreg. Pain / cramps
- Days of flow: _____ Length of cycle: _____
- Date - 1st day last period: _____
- Are you pregnant? yes, no
- If yes, how many months? _____
- How many children do you have? _____
- Birth control method: _____
- Date of last PAP test: _____
- normal, abnormal
- Date of last mammogram: _____
- normal, abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

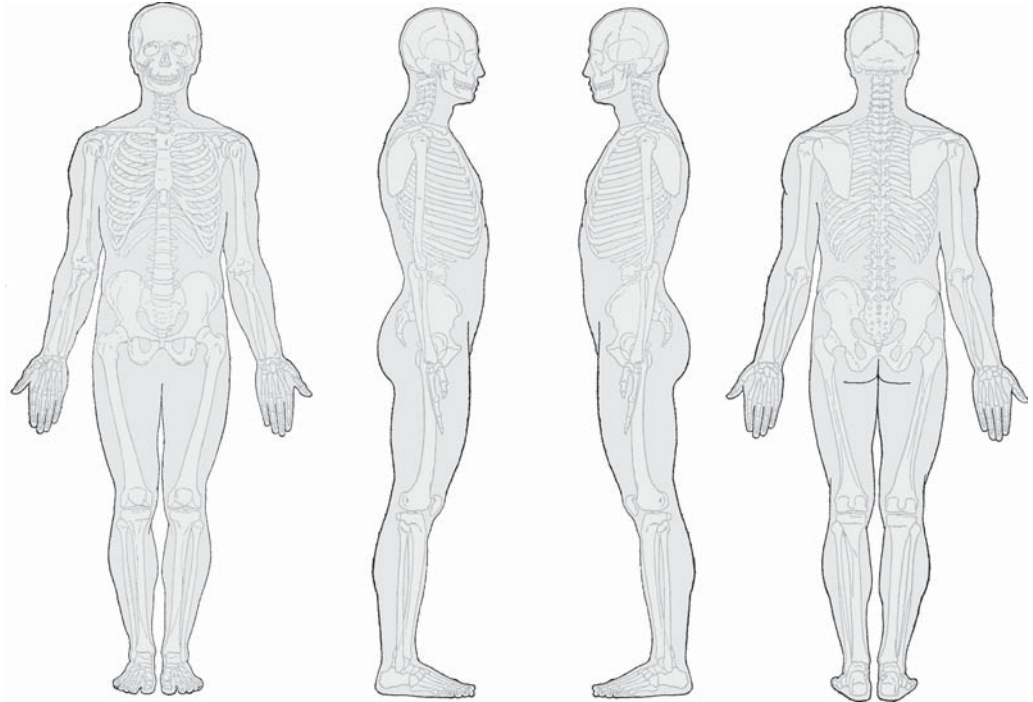
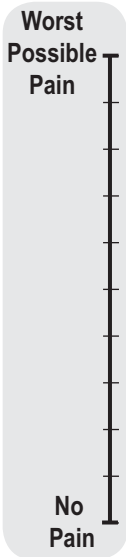
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

Please mark your area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history *If any blood relative has had any of the following conditions, please check and indicate which relative(s)*

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____