

Patient Intake Form Name: _____ **Date:** _____

Appliances or Aids:

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|--------------------------|-----------------------------|----------------------|
| 1. ___ Glasses/Prisms | 5. ___ Prosthetics | 9. ___ Pace Maker |
| 2. ___ Contacts | 6. ___ Implants of any kind | 10. ___ Hearing Aids |
| 3. ___ Orthotics | 7. ___ Braces | 11. ___ Other |
| 4. ___ Joint replacement | 8. ___ Splints | 12. ___ Other |
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Neuropsychological:

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|------------------------|--|
| 13. ___ Seizures | 19. ___ Concussions |
| 14. ___ Depression | 20. ___ Easily stressed |
| 15. ___ Anxiety | 21. ___ Considered/attempted suicide |
| 16. ___ Poor memory | 22. ___ Treated for emotional concerns |
| 17. ___ Foggy thinking | 23. ___ Antidepressant medications |
| 18. ___ Bad Temper | 24. ___ Other neurological or psychological concerns |
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Lifestyle and Social History:

Stress Screening:

- 25. ___ Can you relax when you want?
 - 26. ___ Fall asleep easily?
 - 27. ___ Stay asleep all night?
 - 28. ___ Have trouble dealing with stress?
 - 29. ___ Are you in therapy or counseling? Does it help?
 - 30. ___ Is your family safe to express true emotions?
 - 31. ___ Are romantic relationships fulfilling?
 - 32. ___ Does stress leads to digestive problems?
 - 33. ___ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
 - 34. ___ Do you vent unpleasant emotions in a satisfying way?
 - 35. ___ Do you avoid conflicts at your expense?
 - 36. ___ Do you feel your health is out of your hands?
 - 37. ___ Have you tried to deal with stress, but couldn't succeed?
 - 38. ___ Do you feel capable of resolving your problems, but simply need to know how?
 - 39. ___ How much do you love yourself? 0-----100%
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Do you find any dysfunction or concern in the following areas?

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|------------------------------------|---------------------------------------|
| 40. ___ Relationship with Family | 48. ___ Intimate relationships |
| 41. ___ Relationships with friends | 49. ___ Sex |
| 42. ___ Social Skills | 50. ___ Religious Life _____ |
| 43. ___ Career | 51. ___ Spiritual Path _____ |
| 44. ___ Work | 52. ___ Childhood Religious teachings |
| 45. ___ Leisure Time | 53. ___ Past relationships |
| 46. ___ Hobbies | 54. ___ Childhood |
| 47. ___ Past time activities | 55. ___ School |
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Patient Intake Form Name: _____ **Date:** _____

Habits: List type and quantities where valid

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|---|--|
| 56. ___ Exercise x's/week _____ | 65. ___ Caffeine/pills/coffee/tea/drinks _____ |
| 57. ___ Proper diet (Please list typical daily meals) _____ | 66. ___ Consume Alcohol _____ |
| 58. ___ Participate in community events _____ | 67. ___ Crave sugar/salt/fats _____ |
| 59. ___ Sports _____ | 68. ___ Smoke/chew tobacco _____ |
| 60. ___ Walks _____ | 69. ___ Recreational drugs use _____ |
| 61. ___ Regular Religious activity _____ | 70. ___ Un-protected sex _____ |
| 62. ___ Regular Spiritual activity _____ | 71. ___ Un-necessary risk taking _____ |
| 63. ___ Seatbelts _____ | 72. ___ Road Rage _____ |
| 64. ___ Helmets/Protective gear _____ | 73. ___ Seek conflict _____ |
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Nutritional: List typical ounces/servings per week and type

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|--|-----------------------------------|
| 74. ___ Drink soda oz/wk _____ | 87. ___ Protein _____ |
| 75. ___ Fruit juices oz/wk _____ | 88. ___ Milk, oz/wk _____ |
| 76. ___ Gatorade oz/wk _____ | 89. ___ Dairy, kind _____ |
| 77. ___ Coffee/black tea _____ | _____ |
| 78. ___ Caffeine _____ | 90. ___ Veg, serving/day _____ |
| 79. ___ Chocolate _____ | 91. ___ Fruits, serving/day _____ |
| 80. ___ Alcohol _____ | 92. ___ Vitamins _____ |
| 81. ___ health drinks, i.e. Red Bull _____ | _____ |
| 82. ___ Nutritional Shakes _____ | 93. ___ Supplements _____ |
| 83. ___ Health bars _____ | _____ |
| 84. ___ Protein powders _____ | 94. ___ Food Allergies _____ |
| 85. ___ Cravings salt/sweet/fats _____ | 95. ___ Other _____ |
| 86. ___ Meat _____ | 96. ___ Other _____ |
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Family History: Medical, psychological, social

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|---------------------------------------|--|----------------------------------|
| 97. ___ History of Chief
Complaint | 110. ___ Headaches | 123. ___ Neuromuscular disease |
| 98. ___ Anemia | 111. ___ Heart Disease | 124. ___ Parkinson's |
| 99. ___ Alcoholism | 112. ___ High blood pressure | 125. ___ Physical abuse |
| 100. ___ Allergies | 113. ___ High cholesterol | 126. ___ Sexual abuse |
| 101. ___ ALS (Lou Gerhig's) | 114. ___ Low cholesterol | 127. ___ Seizures |
| 102. ___ Arthritis | 115. ___ Lung disease | 128. ___ Rigid upbringing |
| 103. ___ Asthma | 116. ___ Mental abuse | 129. ___ Rigid Religious beliefs |
| 104. ___ Back/spine problems | 117. ___ Mental illness | 130. ___ Stroke |
| 105. ___ Cancer | 118. ___ Migraines | 131. ___ Suicide (or attempted) |
| 106. ___ Dementia/Alzheimer's | 119. ___ Multiple Sclerosis | 132. ___ Thyroid disease |
| 107. ___ Depression | 120. ___ Muscular Dystrophy | 133. ___ Tremors |
| 108. ___ Diabetes | 121. ___ Neglect | 134. ___ Vascular disease |
| 109. ___ Family violence | 122. ___ Neuropathy (numbness,
tingling, pain, burning) | 135. ___ Other _____ |
| | | 136. ___ Other _____ |
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Signature _____ **Date:** _____

Chief Complaint Worksheet

Patient Name:	Date:				
Symptom/Complaint:					
Onset (What caused it & When did it begin?):					
Provoke (What worsens the complaint: position, activity, stress, food/drinks, motion, etc.):					
Palliative (What makes it better: ice, OTC, massage, position?):					
Quality (Describe what you feel. Is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, pinpoint/general):					
Radiation (Does the pain travel from one area to another?):					
Reference: What is the worse pain you've ever experienced?					
Severity:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">At Its Worst:</td> <td style="width: 50%;">Percent of time:</td> </tr> <tr> <td style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</td> </tr> </table>	At Its Worst:	Percent of time:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
At Its Worst:	Percent of time:				
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10				
Timing: (Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?)					
Possible Social Factor Correlation:					
Possible Hospitalization Correlation:					
Possible Infection Correlation:					
Possible Traumatic Correlation:					
Possible Surgical Correlation:					
Possible Medication Correlation:					
Possible Genetics Correlation:					

Patient Name _____

Date _____

Please mark where you have pain or symptoms. Write down how it feels, such as deep or surface, stabbing or dull, throbbing or constant:

