



Client Intake Form

Last name _____ First _____ Middle _____
 Address _____ Employer _____
 City _____ Zip _____ Occupation _____
 Date of Birth _____ Work Address _____
 Home phone _____ City _____ Zip _____
 Cell phone _____ Work phone _____
 Referring physician _____ Primary physician _____
 Email address _____
 Emergency contact _____ Phone _____ Relationship _____

Physical activities at work:

<input type="checkbox"/>	full-time work	<input type="checkbox"/>	part-time work	<input type="checkbox"/>	student	<input type="checkbox"/>	self-employed
<input type="checkbox"/>	at-home parent	<input type="checkbox"/>	retired	<input type="checkbox"/>	unemployed	<input type="checkbox"/>	other _____

Describe the symptoms that bring you here for treatment? _____

Average pain level ____/10 Worst pain level ____/10 Lowest pain level ____/10

When and how did symptoms begin? _____

Are the symptoms getting better worse same? Similar symptoms in the past? yes no

Describe the nature of your symptoms: _____

Does the pain wake you at night? no yes: while lying still changing positions both

What position(s) do you sleep in? back stomach right side left side all

As the day progresses, do the symptoms: increase decrease not change

What makes the symptoms worse? _____

What makes the symptoms better? _____

What other previous treatment have you had for this condition?

<input type="checkbox"/>	none	<input type="checkbox"/>	massage	<input type="checkbox"/>	acupuncture	<input type="checkbox"/>	PT
<input type="checkbox"/>	medication	<input type="checkbox"/>	hypnosis	<input type="checkbox"/>	injection	<input type="checkbox"/>	brace/tape
<input type="checkbox"/>	joint work	<input type="checkbox"/>	exercise	<input type="checkbox"/>	bed rest	<input type="checkbox"/>	other _____

Results or changes from these treatments? _____

Have you had any of the following imaging/tests? Results _____

<input type="checkbox"/>	x-ray/CT	<input type="checkbox"/>	MRI	<input type="checkbox"/>	NCV/EMG	<input type="checkbox"/>	bone scan
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Since onset of symptoms, have you had: numbness in face and/or genital area
 malaise weakness fever/chills night pain unexplained weight change
 difficulty with control of bowel or bladder function dizziness/fainting numbness



Please indicate how symptoms affect you during the following functional activities:

FUNCTION	no symptoms	discomfort	pain with	unable due to pain
walking				
eating/talking				
work				
personal care				
sleeping				
recreation				
standing				
squatting				
sitting				
stairs				
reading				
driving				
carrying				
reaching				
other _____				

How would you describe your general health? _____
 How often do you exercise (beyond daily activities)? _____
 How would you describe your average stress level? _____

List over-the-counter medications and supplements: _____
 List current prescription medications/remedies: _____

Please list all past surgeries/operations and year: _____

Please list any significant family medical history: _____

Have you ever had/been diagnosed with any of the following conditions?

<input type="checkbox"/>	vision issues	<input type="checkbox"/>	heart issues	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	stroke
<input type="checkbox"/>	hearing issues	<input type="checkbox"/>	blood disorders	<input type="checkbox"/>	allergies	<input type="checkbox"/>	multiple sclerosis
<input type="checkbox"/>	sensory integration issues	<input type="checkbox"/>	circulation disorders	<input type="checkbox"/>	cancer	<input type="checkbox"/>	Parkinson's
<input type="checkbox"/>	metal implant/pacemaker	<input type="checkbox"/>	epilepsy/seizure	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	thyroid disorder	<input type="checkbox"/>	lung issues	<input type="checkbox"/>	head injury	<input type="checkbox"/>	infectious disease
<input type="checkbox"/>	latex sensitivities	<input type="checkbox"/>	asthma	<input type="checkbox"/>	blood pressure	<input type="checkbox"/>	dizziness
<input type="checkbox"/>	kidney issues	<input type="checkbox"/>	stomach/GI issues	<input type="checkbox"/>	neurological issue	<input type="checkbox"/>	other _____

Any other comments or concerns: _____
