INTAKE/DISCHARGE SHEET

Please Print

Patient Information

Name____ Date__________________
Date of Birth ________________ Age _____ Social Security Number _________________
Phone # ____________________________ Cell # ___________________________________
Street Address ____
City _______________________ State ______________________ Zip ________________
E-Mail ____
Occupation____
Employer ____________________________ Business Phone _______________________
Sex: □ Male □ Female Height ______________ Weight _______________
Are you □ Married □ Single □ Domestic Partnership □ Divorced □ Separated □ Widowed
Spouses Name: ____
Health Insurance______________________ ID # _______________ Group # ___________
Do you have any special needs? ____

Present Health

Please Complete Duties Under Duress and Loss of Enjoyment Worksheets

What are your current health concerns? ____
____
What are your goals coming in today? ____
____
Who is your primary care provider? ____
Address ____
Phone ____
Please list any allergies you may have ____
Please list any medications you are currently taking
____
Please list any supplements you are currently taking
____
Describe your current exercise regimen ____

Medical History

Have you ever been treated by a: □ Chiropractor □ Naturoprathic Doctor □ Reflexologist
□ Massage □Acupuncturist □ Other Alternative Practitioner

Family History

(G = Good, P = Poor)

Check applicable	Father	Mother	Grandparent	Sibling	Other (Specify)
Anemia	______	______	_______	_____	_________
Cancer	______	______	_______	_____	_________
Diabetes	______	______	_______	_____	_________
Heart Disease	______	______	_______	_____	_________
High Blood Pressure	______	______	_______	_____	_________
Stroke	______	______	_______	_____	_________
General Health	______	______	_______	_____	_________

Personal History

As a child, did you have any of the following diseases?
□ Scarlet Fever □ Rheumatic Fever □ Diphtheria □ Mumps □ Measles □ German measles
□ Other ____

List any fractures or surgeries you have had with corresponding dates:
____

List other injuries including falls and other traumas and when they occurred:
____

Have you been diagnosed with any disease or disorders and when? _________________
____

Are there any additional health concerns or questions you have? ___________________
____
____

<u>Please Circle the appropriate letter next to each item based on the following:</u>
Y = a condition you have now **N** = never had

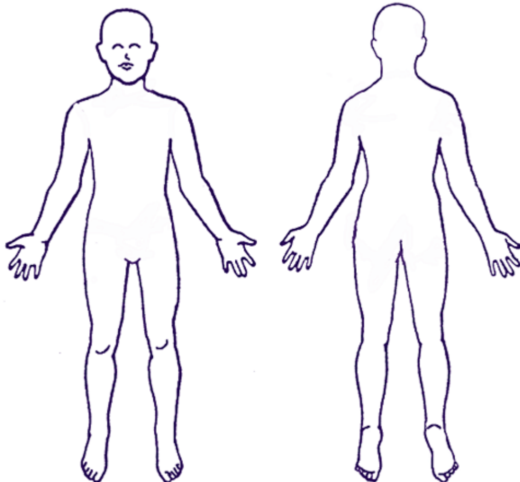
Neck Pain	Y N	R/L Leg Pain/Tingling	Y N
Mid Back Pain	Y N	R/L Foot Pain/Tingling	Y N
Lower Back Pain	Y N	R/L Foot Pain/Tingling	Y N
Extremity Pain	Y N	R/L Hand Pain/Tingling	Y N
Chest Pain	Y N	Fingers/Toes Pain/Tingling	Y N
Muscle Spasms	Y N	Dizziness	Y N
Vision Disturbance	Y N	Heart Disease	Y N
Motion Restriction	Y N	Low/High Blood Pressure	Y N

Sleep Disturbance	Y N	Nausea	Y N
Anxiety	Y N	Vomiting	Y N
Night Sweats	Y N	Liver Disease	Y N
Headaches	Y N	Abdominal Pain	Y N
Head Injury	Y N	Joint Pain/Stiffness	Y N
Impaired Vision	Y N	Arthritis	Y N
Depression	Y N	Broken Bones	Y N
Double Vision	Y N	Fainting	Y N
Ringing in Ears	Y N	Seizures	Y N
Frequent Colds	Y N	Muscle Weakness	Y N
Sinusitis	Y N	Goiter	Y N
Cough	Y N	Spit up Blood	Y N
Asthma	Y N	Bronchitis	Y N
Emphysema	Y N	Difficulty Breathing	Y N
Diabetes	Y N	Sexual Difficulties	Y N
Mood Swings	Y N	Memory Loss	Y N
Drug/Alcohol Abuse	Y N	Thyroid Problem	Y N
Pacemaker/Defibrillator	Y N		

Women Only:

Currently Pregnant Y N

Please indicate on the picture below your problem areas. Please use the following symbols provided:



= = - Numbness
OO – Pins and Needles
XX – Aching
//// - Stabbing

Pain scale: (1-10 - 1 = low, 10 = High)

Neck: ________________
Mid Back: ________________
Low Back: ________________
Extremities: ________________

Patients Signature: __________________________________ Date: ________________