the[clinic] patient intake form

patient[information]

Last Name: _____ First Name: _____

Sex: ☐ M ☐ F Age: _____ Date of Birth (YYYY/MM/DD): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (Home): _____ Phone (Work): _____ Phone (Cell): _____

Email Address: _____ Occupation: _____

Emergency Contact Person: _____ Phone: _____

Medical Doctor: _____ Phone: _____

complaint[history]

What is your main complaint? _____

When did you first notice this complaint? _____

What caused this complaint? _____

Describe your current pain/discomfort: _____

How often does you pain occur? _____

Is your condition getting worse? ☐ Y ☐ N

Rate your pain/discomfort: (none) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (worst pain ever)

What activities aggravate your complaint? _____

What activities relieve your complaint? _____

Does your pain radiate or shoot anywhere else? If so, where?

_____

Have you received any treatment for this complaint? If so, what kind of treatment?

_____

Have you ever been treated for the same/similar complaint in the past? If so, when?

_____

the[clinic] patient intake form

health[survey]

Do you have any ongoing medical problems or disabilities?

_____

_____

Please list dates and descriptions of any previous accidents or surgeries you have had.

_____

_____

Please list any medications you are currently taking and what you are taking them for.

_____

_____

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week? _____

Are you a smoker? ☐ Y ☐ N If yes, how many packs per day? _____

family[history]

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Children: _____

Please check if any of your family members has or ever had any of the following conditions, and if so, how are they related to you?

☐ Cancer _____ ☐ Arthritis _____

☐ Heart Disease _____ ☐ High Cholesterol _____

☐ Stroke _____ ☐ Hypertension _____

☐ Diabetes _____ ☐ Other _____

patient[signature]

The information I have provided on this form is true and accurate. I will inform the[clinic] of any changes to my status. I also agree and understand that I am fully responsible for the payment of all charges relating to my visit to the[clinic].

I understand that all services at the[clinic] require 24 hour notice for cancellation and that if I do not provide 24 hours notice I am fully responsible for the full service fee.

Signature: _____ Date: _____