Name:						
DOB:						
Chart:						
Age:						
Date:						
Patient Intake Sheet						
Height: Weight: Dominant Hand:	nd: 🗌 Right 🔲 Left		Affe	cted Side:	] Right 🗌 L	eft 🗌 Both
Referring Physician:	Primary Car	e Physician:				
*What specific problem are you being seen for today	y?					
Date of Injury / Start of Symptoms:Is	s it getting better o	or worse?				
Type of Symptoms (Check all that apply):	Pain	Numbness	U Weaknes	ss 🗌 Inst	tability	Stiffness
Quality of Symptoms (Check all that apply):	Sharp	Stabbing	Throbbin	ng 🗌 Pin	s and Needles	
When do Symptoms occur (Check all that apply):	Always	Night	🗌 Day	🗌 Mo	rning	
Pain Level (1-10) :	Lifting	After Activity		At ]	Rest	
Have you been seen for this problem before?	No		When?			
Any previous treatment?  Medication  Splint	X-Rays	Injections	☐ Therapy	🗌 Oth	ner:	
Past Medical Problems?  Hypertension Heart Disease	Diabetes Mellitus		Other:			
Previous Surgeries (please list):						
Medications:						
Allergies:						
	Cancer Rheumatoid Arthritis					
Family History of Disease:  Lupus Cancer	Rheumatoid Arth	ritis 🗌 Otl	ner:			
				o?		
Occupation:H	Iow long have you	ı been at your	current job	)?		
Occupation:H Are you currently working?YesNo A		ı been at your , activities, ho	current job	)?		
Occupation:H Are you currently working? Yes No A Marital Status: Single Married	Iow long have you avocations (sports	ı been at your	current job	?		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       C         Do you have children?       Yes       No       If	Iow long have you avocations (sports Divorced f yes, how many?	i been at your , activities, ho U Widowe	current job obbies): ed	»?		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If	Iow long have you avocations (sports ] Divorced	i been at your , activities, ho U Widowo acks per day?	current job obbies): ed	<u>.</u>		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If	Iow long have you vocations (sports ] Divorced f yes, how many? f yes, how many p	i been at your , activities, ho U Widowo acks per day? rinks per wee	current job bbies): 2d k?	»?		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If	Iow long have you Avocations (sports Divorced f yes, how many? f yes, how many p f yes, how many d f yes what drugs?	i been at your , activities, ho Widowe acks per day? rinks per wee For how long	current job bbies): 2d k? ?	)?		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema	Iow long have you Avocations (sports Divorced f yes, how many? f yes, how many p f yes, how many d f yes what drugs?	i been at your , activities, ho Widowe acks per day? rinks per wee For how long	current job bbies): ed k? ?	5?		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema         Ears/Nose/Throat:       Headaches       Blurred Vision       It	Iow long have you avocations (sports Divorced f yes, how many? f yes, how many p f yes, how many d f yes what drugs? following? (Chec	i been at your , activities, ho Widowa acks per day? rinks per wee For how long k all that ap	current job bbbies): ed k? ? bly) r	>?		
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema	Iow long have you vocations (sports Divorced f yes, how many? f yes, how many p f yes, how many d f yes what drugs? following? (Chec Psoriasis	i been at your , activities, ho Widowe acks per day? rinks per wee For how long k all that ap Cance	r current job bbies): ed k? ? bly) r ng Loss	?	Fever	
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema         Ears/Nose/Throat:       Headaches       Blurred Vision       Stature	Iow long have you avocations (sports Divorced f yes, how many p f yes, how many p f yes, how many d f yes what drugs? <b>following? (Chec</b> Desoriasis Loss	i been at your , activities, ho Widowe acks per day? rinks per wee For how long k all that ap Cance	current job bbies): ed k? ? bly) or ng Loss tension			
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       I         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema         Ears/Nose/Throat:       Headaches       Blurred Vision       Cardiac/Heart:       Palpitations       Chest Pains	Iow long have you vocations (sports Divorced f yes, how many? f yes, how many d f yes what drugs? following? (Chec Psoriasis Loss Swollen Ank	i been at your , activities, ho Widowa acks per day? rinks per wee For how long <u>k all that ap</u> Cance Hearin les Hyper Whee	current job bbies): ed k? ? bly) r ng Loss tension zing	Rheumatic	of Breath	er Disease
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema         Ears/Nose/Throat:       Headaches       Blurred Vision       Cardiac/Heart:       Palpitations       Chest Pains         Lungs/Respiratory:       Lung Disease       Emphysema       Emphysema	Iow long have you vocations (sports Divorced f yes, how many? f yes, how many p f yes, how many d f yes what drugs? <b>following? (Chec</b> Psoriasis Doss Swollen Ank Asthma	activities, ho Widowa acks per day? rinks per wee For how long <b>k all that ap</b> Cance Hearin les Hyper Whee ain Blood	current job bbies): ed k? ? bly) r ng Loss tension zing	Rheumatic Shortness of	of Breath	er Disease
Occupation:       H         Are you currently working?       Yes       No       A         Marital Status:       Single       Married       D         Do you have children?       Yes       No       If         Do you smoke?       Yes       No       If         Do you drink alcohol?       Yes       No       If         Have you used illicit drugs?       Yes       No       If         Do you currently, or have you ever had any problems with the f       Skin:       Rashes       Eczema         Ears/Nose/Throat:       Headaches       Blurred Vision       Cardiac/Heart:       Palpitations       Chest Pains         Lungs/Respiratory:       Lung Disease       Emphysema       Gastrointestinal:       Ulcers       Weight Loss	Iow long have you vocations (sports Divorced f yes, how many? f yes, how many p f yes, how many d f yes what drugs? <b>following? (Chec</b> Psoriasis Doss Swollen Ank Asthma Blood in Urin	activities, ho Widowa acks per day? rinks per wee For how long <b>k all that ap</b> Cance Hearin les Hyper Whee ain Blood	current job bbbies): ed k? ? bly) r ng Loss tension zing in Stools	Rheumatic Shortness of	of Breath	er Disease

## \*Please have intake paperwork completed 15 minutes before your appointment or you may need to be rescheduled.

The information above is accurate to the best of my knowledge: Patient Signature:

Date: