PATIENT INTAKE FORM

PATIENT INFORMATION

Name

DOB _____ Occupation _____

Address _____

Phone _____ Email _____

Emergency Contact _____ Phone _____

How did you learn about us? _____

- ☐ GP
- ☐ Facebook
- ☐ Passing
- ☐ Friend/ Family
- ☐ Google
- ☐ Instagram
- ☐ Talk
- ☐ Other _____

HOW CAN WE HELP YOU?

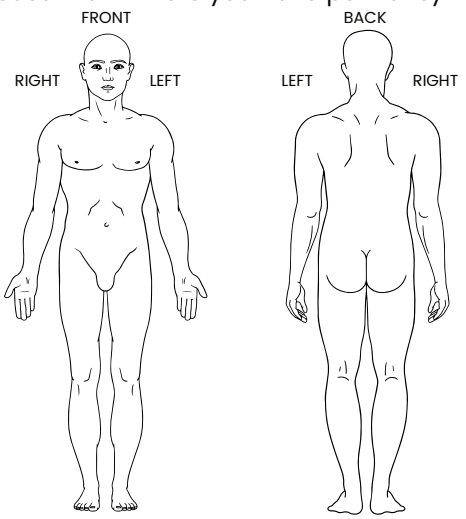
What brings you in today?

_____

If you are already experiencing symptoms, what are they?

_____

Please mark where you have pain or symptoms:



What does it feel like? (check where appropriate)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other _____

Out of 10, please rate the severity of your symptoms:

0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

How is this symptom/ condition interfering with your life? (check where appropriate)

	NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT
WORK	☐	☐	☐	☐
EXERCISE	☐	☐	☐	☐
SLEEP	☐	☐	☐	☐
SELF CARE	☐	☐	☐	☐
MOOD	☐	☐	☐	☐
ENERGY	☐	☐	☐	☐
RELATIONSHIPS	☐	☐	☐	☐

PATIENT WELLNESS ASSESSMENT

DISEASE
MULTIPLE MEDICATIONS
POOR QUALITY OF LIFE
BODY HAS LIMITED FUNCTION

POOR HEALTH
SYMPTOMS
DRUG THERAPY
LOSING NORMAL FUNCTION

NEURTRAL
NO SYMPTOMS
NUTRITION INCONSISTENT
EXERCISE SPORADIC

GOOD HEALTH
REGULAR EXERCISE
GOOD NUTRITION
WELLNESS EDUCATION

OPTIMAL HEALTH
100% FUNCTION
ACTIVE PARTICIPATION
WELLNESS LIFESTYLE

Based on the Illness- Wellness Continuum diagram above:

What number do you think represents your health today? _____

In what direction do you want your health to be headed? (circle)

DISEASE POOR HEALTH NEUTRAL GOOD HEALTH OPTIMAL HEALTH

What are your health goals?

Immediate: _____

Short Term: _____

Long Term: _____

HEALTH AND ILLNESS HISTORY

Please check the box for any condition you have or have had:

- ☐ Neck Pain
- ☐ Headaches/ Migraines
- ☐ Anxiety
- ☐ Cardiovascular Issues
- ☐ Sinus Issues
- ☐ Arthritis
- ☐ Cancer
- ☐ Back Pain
- ☐ Allergies
- ☐ Asthma/ Lung Issues
- ☐ Circulation Issues
- ☐ Depression
- ☐ Sports injury
- ☐ Digestive Issues
- ☐ Bruise Easily
- ☐ High Blood pressure
- ☐ Varicose veins
- ☐ Foot / Ankle Issues
- ☐ Knee / Hip Issues
- ☐ Gout
- ☐ Surgery
- ☐ Elbow/ Wrist/ Hand Issues
- ☐ Osteoporosis
- ☐ Immune Issues
- ☐ Hepatitis/ Liver Disease
- ☐ Lymphatic Issues
- ☐ Reproductive Issues
- ☐ Diabetes
- ☐ Tinnitus/ Ear Issues
- ☐ Chest Pain
- ☐ Scoliosis
- ☐ TMJ Issues
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ Blood clot
- ☐ Urinary Issues
- ☐ Endocrine Issues (thyroid)
- ☐ Sciatica
- ☐ Other: _____

Have you experienced any major traumas(RTA/ Work Accidents/ Hospitalisations/ Sport Injuries)? (please circle)

YES NO

What happened? _____

Are you on any medication or supplements? (please circle)

YES NO

What are they? What are they for? _____

_____

Do you have any children or are currently pregnant? (please circle)

YES NO

How many children do you have? _____

HISTORY

Name _____ Date _____

Site

Onset

Course

Radiation

Associated Factors

Timing

Exacerbating Factors

Relieving Factors

Severity

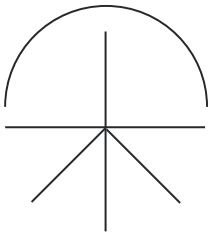
Additional Information

PHYSICAL EXAM

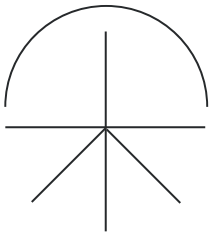
Name _____ Date _____

Range of Motion

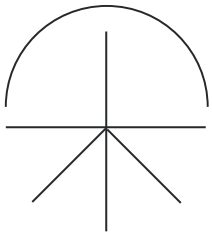
CX
L R



Tx
L R



Lx
L R



Motion Palpation

L			R	
B	A		A	B
		C0 C1		
		C1 C2		
		C2 C3		
		C3 C4		
		C4 C5		
		C5 C6		
		C6 C7		
		C7 T1		
		T1 T2		
		T2 T3		
		T3 T4		
		T4 T5		
		T5 T6		
		T6 T7		
		T7 T8		
		T8 T9		
		T9 T10		
		T10 T11		
		T11 T12		
		T12 L1		
		L1 L2		
		L2 L3		
		L3 L4		
		L4 L5		
		L5 S1		
		SIJ		

A= Tenderness
B= Stiffness

Regional and Functional Exam