Patient Intake Form

Patient Name: _____

Cheif Health Complaints

Please list the specific issues you are experiencing at this time and indicate the severity on a scale of 1 to 10 with ten being most severe.

1 _____ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

2 _____ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

3 _____ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

4 _____ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

5 _____ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Previous Conditions

Days lost from work: _____ Date of last physcal examination: _____

Have you sought care for another health condition in the past year? ☐ Yes ☐ No

If yes, what condition other than your primary complaint? _____

Was treament administered? ☐ Yes ☐ No If yes, please describe the treatment.

_____

_____

Do you take medications? ☐ Yes ☐ No If yes, please list medications.

_____

_____

Please check any of the following that you have had, or have at the present:

- ☐ Heart (Surgery, Disease, Attack)
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Ulcers
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Contact Lenses
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Hepatitis A (infections) B (Serum)
- ☐ Venereal Disease
- ☐ A.I.D.S
- ☐ H.I.V. Positive
- ☐ Cold Sores/Fever Blisters
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease