INTAKE FORM

Today's Date:
Name:

Have you ever been told you have:		**In the past 3 months have you had or do you experience:**	
Cancer ?	Yes/No	A change in your health ?	Yes/No
Diabetes ?	Yes/No	Nausea/Vomiting ?	Yes/No
High blood pressure ?	Yes/No	Fever/chills/sweats ?	Yes/No
Heart disease ?	Yes/No	Unexplained weight change ?	Yes/No
Angina/chest pain ?	Yes/No	Numbness or tingling ?	Yes/No
Stroke ?	Yes/No	Changes in appetite ?	Yes/No
Osteoporosis ?	Yes/No	Difficulty swallowing ?	Yes/No
Osteoarthritis ?	Yes/No	Changes in bowel or bladder function ?	Yes/No
Rheumatoid arthritis ?	Yes/No	Color of urine/ stool change	Yes/No
		Shortness of breath ?	Yes/No
		Dizziness ?	Yes/No
		Upper respiratory infection ?	Yes/No
		Urinary tract infection ?	Yes/No
		Change in your balance (falls)	Yes/No
		Does your pain change with eating	Yes/No
		Pelvic pain	Yes/No
		Pain with intercourse	Yes/No
		Recent major trauma /surgery/ immobilization	Yes/No
		Entire calf swelling	Yes/No

		Do you have a history of:	
Do you or have you in the past smoked tobacco? Yes/No	Yes/No	Headaches ?	Yes/No
If yes, How many Packs/day ?			
How many Years?	Yes/No	Bronchitis ?	Yes/No
Last tobacco use ?		Kidney disease ?	Yes/No
Do you drink alcoholic beverages?	Yes/No	Rheumatic fever ?	Yes/No
If yes, how many drinks do you routinely have per week?		Ulcers ?	Yes/No
		Sexually transmitted disease ?	Yes/No
Date of last physical examination:		Seizures ?	Yes/No
Are you currently:			
Pregnant ?	Yes/No		
Depressed ?	Yes/No		
Under Stress ?	Yes/No		

During the past month have you been feeling down, depressed or hopeless? Yes/No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes/No

Is this something with which you would like help?..... Yes/No

Select from 0 to 10											
0-1 No Pain, 2-8 Pain Scale (please circle in appropriate box, 9-10 Maximum Pain											
Pain today?	0	1	2	3	4	5	6	7	8	9	10
Maximum - past several days	0	1	2	3	4	5	6	7	8	9	10
Minimum - past several days	0	1	2	3	4	5	6	7	8	9	10

Please indicate which body part you have pain in:

My goal for therapy is:

CURRENT SYMPTOMS:

Where are you currently having symptoms?	
What date (roughly) did you present pain start?	
Did your pain start**:**	Suddenly Gradually By Injury
Please describe your symptoms**:**	
Have you ever had this problem before**:**	
If yes, when:	
What aggravates your pain? (like sitting, standing etc)	

What eases your pain?	
Are your symptoms:	
How are you able to sleep at night?	Fine Moderately Difficult With Difficulty
Do you have a problem with?	Hearing Vision Speech Communication
My symptoms are worse in the:	Morning Afternoon Evening Night
My symptoms are least in the:	Morning Afternoon Evening Night
List medications currently using:	

_____ _____

Your Name Signature & Date