Patient Intake Form

Patient Name: ______________________________ Date: ______________

Age: ______________ Height: ______________ Weight: ______________

Are you on work restrictions from your physician? ☐ Yes ☐ No If yes, please explain: ______________

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Are you latex sensitive? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Do you have diabetes? ☐ Yes ☐ No

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

List any medication(s) you are allergic to: ______________________________

Any other medical conditions? ______________________________

Have you had recent surgery? ☐ Yes ☐ No Type: ______________ Date: ______________

What date, approximately, did your present symptoms start? ______________________________

What do you think caused your symptoms? ______________________________

Treatment received so far: (physical therapy, injections, surgery, chiropractic, etc.)? ______________

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Have you ever had this problem before? ☐ Yes ☐ No Treatment received: ______________

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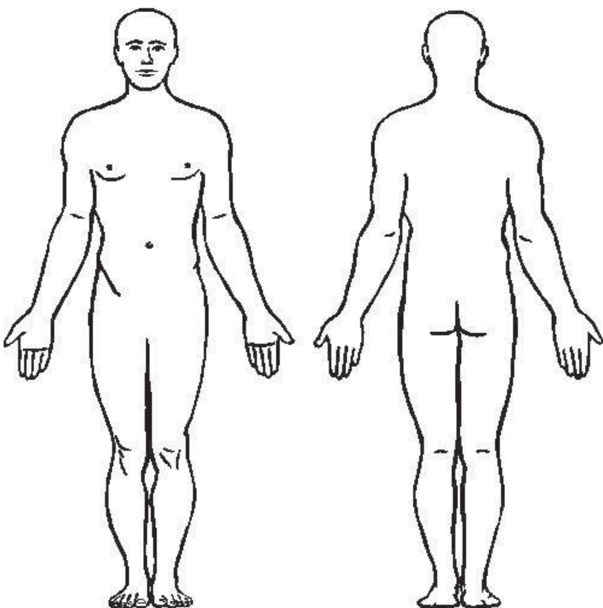
Body Chart

Please mark the areas where you feel symptoms.



Have you recently noted any of the following?

- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Unexplained weight loss/gain
- ☐ Difficulty maintaining balance
- ☐ Falls
- ☐ Numbness or tingling
- ☐ Muscle Weakness
- ☐ Dizziness/lightheadedness
- ☐ Heartburn/indigestion
- ☐ Difficulty Swallowing
- ☐ Changes in bowel or bladder function
- ☐ Constipation
- ☐ Diarrhea
- ☐ Shortness of Breath
- ☐ Depression
- ☐ Cough
- ☐ Headaches