Client Intake Form

Date: ______________________

Name: ____ Sex: ❑ Male ❑ Female

Address: ____

City: __________________________________ State: ________________ Zip: ______________

Daytime Phone #: ________________________ Evening Phone #: ________________________

Social Security #: ________________________ Driver's License #: ________________________

Date of Birth: ____________________________ Occupation: _________________________

Employer: ____

Employer's Address: ____

Marital status: ❑ Single ❑ Married

Children's Names and Ages: ____

Name of Spouse/Significant Other: ____

Preferred Appointment Day and Time: ____

Insurance Carrier: ________________________ Policy #: ______________________________

ID #: __________________ Group #: ___________________ Claim #: __________________

Adjuster's Name: ____

Adjuster's Address: ____

City: __________________________________ State: __________ Zip: ________________

Telephone #: ____ Extension: ___________

Time and Date of Insurance Verification: ____

Primary Health Care Provider: ____

Provider's Address: ____

City: __________________________________ State: __________ Zip: ________________

Telephone #: ____ Extension: ___________

Permission to Consult with Primary Provider? ❑ No ❑ Yes ________ (please initial if yes)

In Case of Emergency, Please Notify:

Name: ___________________________________ Telephone #:_______________________________

Relationship: ____

*Please note that if you are billing insurance companies, your clients will have to fill out a claim form (most likely a HCFA-1500) that duplicates most of this information.

Client Health Information Sheet

Name: ______________________________ Date: ____________

Who referred you to this office? Name: ______________________________

❑ Yellow Pages ❑ Advertisement ❑ Sign ❑ Other: ____________

Present symptoms: What is your major complaint or condition you want to improve? ____________

____

When did you first notice major complaints? ______________________________

What brought it on? ______________________________

____

What activities aggravate the condition? ______________________________

____

Is this condition getting progressively worse? ❑ Yes ❑ No

Please Explain: ______________________________

____

Does this condition interfere with work? ❑ Y ❑ N Sleep? ❑ Y ❑ N Daily Routine? ❑ Y ❑ N

Please Explain: ______________________________

____

What have you done to get relief? ______________________________

____

Has there been a medical diagnosis? ❑ Yes ❑ No

If so, by whom? ______________________________

Please Explain: ______________________________

____

Have you had X-rays taken? ❑ Yes ❑ No

If yes, by whom? ______________________________

What are your intentions or expectations for this visit? ______________________________

____

____

Are you now under medical/therapeutic treatment? ❑ Yes ❑ No

If yes, for what condition? ______________________________

____

____

Please list your care provider's name and phone number: ______________________________

____

List any medications (including aspirin) and nutritional supplements you are taking: __________

____

Describe the exercise activities you do (include frequency): ______________________________

____

List other therapies you receive: ______________________________

____

Please list (date and description) any accidents or operations: ______________________________

____

Please list any additional comments regarding your health and well-being: ______________________________

____

____

____

____

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- ❑ Headaches
- ❑ Joint stiffness/swelling
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Back, hip pain
- ❑ Shoulder, neck, arm, hand pain
- ❑ Leg, foot pain
- ❑ Chest, ribs, abdominal pain
- ❑ Problems walking
- ❑ Jaw pain/TMJ
- ❑ Tendinitis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone or joint disease
- ❑ Other: ____________________

Circulatory and Respiratory

- ❑ Dizziness
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Pressure sores
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Lymphedema
- ❑ Other: ____________________

Skin

- ❑ Rashes
- ❑ Allergies
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Moles
- ❑ Acne
- ❑ Cosmetic surgery
- ❑ Other: ____________________

Digestive

- ❑ Nervous stomach
- ❑ Indigestion
- ❑ Constipation
- ❑ Intestinal gas/bloating
- ❑ Diarrhea
- ❑ Diverticulitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Adaptive aids
- ❑ Other: ____________________

Nervous System

- ❑ Numbness/tingling
- ❑ Twitching of face
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Chronic Fatigue Syndrome
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other: ____________________

Reproductive System

- ❑ Pregnancy:
  - ❑ Current ❑ Previous
- ❑ PMS
- ❑ Menopause
- ❑ Pelvic Inflammatory Disease
- ❑ Endometriosis
- ❑ Hysterectomy
- ❑ Fertility concerns
- ❑ Prostate problems

Other

- ❑ Loss of appetite
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Difficulty concentrating
- ❑ Drug use ________________
- ❑ Alcohol use ______________
- ❑ Nicotine use _____________
- ❑ Caffeine use _____________
- ❑ Hearing impaired
- ❑ Visually impaired
- ❑ Burning upon urination
- ❑ Bladder infection
- ❑ Eating disorder
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Post/Polio Syndrome
- ❑ Cancer
- ❑ Infectious disease (please list) ____________________
- ❑ Other congenital or acquired disabilities (please list)________ ____________________
- ❑ Surgeries ________________
- ❑ Other: ____________________

For clients who need mobility assistance, please give your height: ________ weight: ________

Please list any additional comments regarding your health and well-being: ______________________________

____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: ____ Date: ____________________