bwellhealth

"eat well, sleep well, live well…bwell"

Patient Intake Form

Patient Name: _____
Last Name

_____
First Name Middle Initial

Preferred Name: _____ Age:_____

DOB: _____ SS# _____

Address: _____

City: _____ State: _____

Zip: _____ Gender ☐ M ☐ F

Home Phone:_____ Cell: _____

E-mail address: _____

Are you (circle one): Single Married Widowed

Divorced Separated Minor Partner Other

Occupation: _____

Employer:_____

Employer Address:_____

Emergency Contact: _____
Name

_____ (____)_____
Relationship Phone

INSURANCE

Insurance Company:_____

ID#:_____

Group#:_____

WORKERS COMP/AUTO INJURY

Policy#:_____

Adjustor:_____

Phone:_____

Date of Injury:_____ Last Worked:_____

How did you learn about us? (Circle all that apply)

Internet Print/Media

Direct Mail Insurance Website

Physician:_____

At an Event:_____

Patient:_____

What services are you here for? (Check all that apply)

☐ Chiropractic ☐ Yoga/Meditation

☐ Acupuncture ☐ Foot Orthotics

☐ Massage ☐ Gait Analysis

☐ Nutrition ☐ Sauna/Infrared Therapy

☐ Physician Consult ☐ Post-Concussion Rehab

What health issues would you like us to address on your initial visit? (Please rank by priority):

1. _____
2. _____
3. _____

When did your symptoms appear? _____

Rate your pain on a scale from 1 (least) to 10 (severe):

0 1 2 3 4 5 6 7 8 9 10

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing

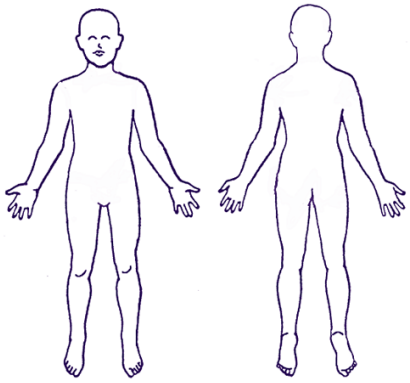
☐ Burning ☐ Ache ☐ Stiff ☐ Shooting ☐ Numb

☐ Swelling ☐ Cramps ☐ Tingling ☐ Other

Frequency: ☐ Constant ☐ Frequent ☐ Intermittent

☐ Occasional

Please mark the areas of the body where you are experiencing pain.



Does your pain radiate? No Yes, where?_____

What makes it worse?_____

_____

What makes it better?_____

_____

Have you seen any other physicians for this condition (if so please list):

_____

_____

_____

Medical History: (Circle all that apply)

AIDS/HIV	Diabetes	Lung Disease	Rheumatic Fever
Alcoholism	Emphysema	Measles	Scarlet Fever
Anemia	Epilepsy	Migraine Headaches	Seizures
Anorexia	Fractures	Miscarriage	Stroke
Anxiety	Glaucoma	Mononucleosis	Suicide Attempts
Appendicitis	Goiter	Multiple Sclerosis	Thyroid Problems/Disease
Arthritis	Gonorrhea	Mumps	Tonsillitis
Asthma	Gout	Osteoporosis	Tuberculosis
Bleeding Disorders	Heart Disease	Pacemaker	Tumors, Growths
Breast Lump	Hepatitis	Parkinson's Disease	Typhoid Fever
Bronchitis	Hernia	Pinched Nerve	Ulcers
Bulimia	Herniated Disk	Pneumonia	Vaginal Infections
Cancer	Herpes	Polio	Venereal Disease
Cataracts	High Cholesterol	Prostate Problem	Whooping Cough
Chemical Dependency	Hypertension	Prosthesis	Other_____
Chicken Pox	Kidney Disease	Psychiatric Care	
Depression	Liver Disease	Rheumatoid Arthritis	_____

Family Medical History: Please indicate with a check mark if any family members have had any of the following:

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism								
Anxiety/Depression								
Arthritis								
Bone/Joint Problems								
Cancer								
Diabetes, Type 1 (Childhood Onset)								
Diabetes, Type 2 (Adult Onset)								
Heart Attack: Over age 60								
Heart Attack: Under age 60								
Heart Murmur								
Heart Problems								
High Blood Pressure								
High Cholesterol								
Seizures								
Stroke								

Medication(s)/ Herbal Supplements:

Medication/Herbal Supplements	Strength	Dosage	Frequency	Date Started	Duration

Surgical History:

Injuries/Surgeries you have had Description Date

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Car Accidents _____

Workers Comp Injuries _____

MRI/Xrays

MRI/Xray	Date	Location	Body Part	Reason

Primary Care Physician:

Name: _____ Facility: _____

Address: _____ Phone: _____

Social History:

Do you use tobacco? (Amount per Day) _____ How long:_____

Do you use recreational drugs (cocaine, marijuana, etc.)? Yes No

Do you drink Alcohol (Amount per Week) _____ Do you drink Coffee (Cups/Day)_____

Stress Level: Low Moderate Severe Reason:_____

Do you have allergies? Yes No If yes, what?_____

Do you exercise: None 1-2x/week 3-4x/week 5-6x/week every day

What is your activity level at work? Sitting Standing Light Labor Heavy Labor

Females Only:

Are you pregnant? Yes No Due Date:_____ When was your last period?_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____

Signature of patient or parent of minor Date