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? ______________

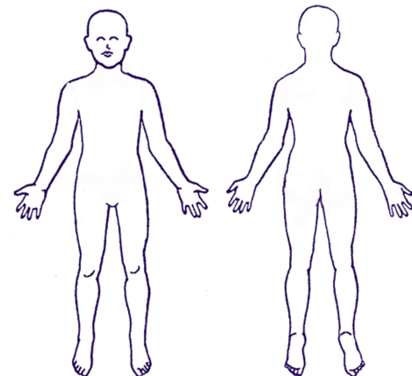
Rate your pain on a scale from 1 (least) to 10 (severe):

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

____

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