Complete Wellness & Integrated Health Center
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Patient Intake Form

Date: _____

_____

(Legal) First Name **(Legal) MI** **(Legal) Last Name** **Birthday**

Gender: [ ] Male [ ] Female **Marital Status:** [ ] Single [ ] Married [ ] Other _____

[ ] Employed [ ] Full Time Student [ ] Part Time Student [ ] Other _____

Social Security # _____ - _____ - _____ How did you hear about our office? _____

Race: [ ] White [ ] Black or African American [ ] Hispanic or Latino [ ] Asian [ ] American Indian or Alaska Native

[ ] Native Hawiian/Other Pacific Islander [ ] Other _____

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latina [ ] Other _____

Language: [ ] English [ ] Spanish [ ] Other _____

Email: _____

Street: _____Apt. _____PO Box: _____

City: _____ State: _____ Zip: _____

Contact info: Main Ph: _____-_____-_____ Cell Ph: _____-_____-_____ Other Ph: _____-_____-_____

Occupation: _____ Employer: _____

Employer Address: _____

Street City State Zip

Emergency Contact: Name: _____ Relationship: _____ Phone: _____-_____-_____

What is your main complaint(s)? _____

Is Condition (Circle what applies): Job Related/ Auto Accident/ Home Injury/ Fall/ Unknown/
Other_____

Mark the FREQUENCY of your PAIN: (Circle all that apply):
Constant (75-100%) Frequent (50-75%)
Occasional (25-50%) Intermittent (0-25%)

Describe the Pain: (Circle all that apply):
Dull / Sharp / Ache / Throb / Burning / Numb/ Tingling / Cramping
Spasm / Shooting

Other Conditions RELATED TO INJURY: Headaches/ Neck Pain / Shoulder Pain / Pain between Shoulders/Low Back Pain / Buttock Pain / Hip Joint Pain / Arm or Hand tingle or numb / Leg or Foot tingle or numb

X-RAY CONSENT: I give consent to an x-ray examination if needed to determine the appropriateness of care. I will be informed of any findings.

WOMEN ONLY-Pregnancy Release: This is to certify that to the best of my ability I am not pregnant and I give my permission to perform an x-ray evaluation. I understand the risks of an x-ray to an unborn child.
(Please circle what applies): I am or may be pregnant / I am NOT pregnant

HIPAA Privacy Rule: This office is required by law to maintain the privacy and confidentiality of your protected health information. By signing this form, I release this office form the liability and giver permission to use my first and last name for the purpose of speaking with me in the presence of others. I understand that I may request a detailed copy of the HIPAA privacy rule at any time.

I have read and fully understand the above statements and accept care on this basis.

Patient / Parent / Advocate Signature: _____ Date: _____

Check Any Past Medical Problems:

[ ] Acid Reflux
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Asthma
[ ] Cancer:
Type _____
[ ] Chronic UTI's
[ ] Congestive Heart Failure
[ ] COPD
[ ] Coronary Artery Disease
[ ] Crohn's
[ ] Depression
[ ] Diabetes: #of years _____
[ ] Diverticulitis
[ ] Enlarged Prostate
[ ] Glaucoma
[ ] Gout
[ ] Heart Attack
[ ] Hepatitis C
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] HIV
[ ] IBS
[ ] Kidney Stones
[ ] Liver Disease
[ ] Lupus
[ ] Migraine Headaches
[ ] Neurologic Disease
[ ] Osteoarthritis
[ ] Osteoporosis
[ ] Peptic Ulcer Disease
[ ] Peripheral Vascular Disease
[ ] Renal Disease
[ ] Rheumatoid Arthritis
[ ] Seizure Disorder
[ ] Stroke
[ ] Thyroid Disease
[ ] Valvular Heart Disease

Other: _____

Check Any Past Surgical History:

	Date		Date		Date
[ ] Adrenalectomy	_____	[ ] Cystoscopy	_____	[ ] Laparoscopy	_____
[ ] Appendectomy	_____	[ ] Gallbladder Removal	_____	[ ] Liver Biopsy	_____
[ ] Back Surgery	_____	[ ] Gastric Bypass	_____	[ ] Kidney Removal	_____
[ ] Bladder Removal	_____	[ ] Hernia Repair	_____	[ ] Pacemaker	_____
[ ] Heart Bypass	_____	[ ] Hip Replacement	_____	[ ] Tonsillectomy	_____
[ ] Colon Surgery	_____	[ ] Kidney Stone Removal	_____		
[ ] Heart Stent	_____	[ ] Knee Replacement	_____		

Gender Specific: Females

[ ] Bladder Suspension	_____	[ ] Hysterectomy	_____	[ ] Pubovaginal Sling	_____
[ ] Breast Biopsy	_____	[ ] Mastectomy	_____	[ ] Tubal Ligation	_____
[ ] Cesarean Section, # ____	_____				

Other:

_____

_____

Gender Specific: Males

[ ] Prostate Biopsy	_____	[ ] Penile Prosthesis	_____	[ ] Varicocele Ligation	_____
[ ] Prostate Surgery	_____	[ ] Spermatocelectomy	_____	[ ] Vasectomy	_____
[ ] Hydrocelectomy	_____	[ ] Testicle Removal	_____		

Other:

_____

_____

Check Any Family History of Illness:

	Relationship	Alive	Age of Death		Relationship	Alive	Age of Death
[ ] Blood Disease	_____	[ ] Y [ ] N	_____	Bowel Disease	_____	[ ] Y [ ] N	_____
[ ] Cancer:	_____	[ ] Y [ ] N	_____	[ ] Kidney Stones	_____	[ ] Y [ ] N	_____
Type _____	_____	[ ] Y [ ] N	_____	[ ] Migraines	_____	[ ] Y [ ] N	_____
[ ] Coronary Artery Disease	_____	[ ]Y [ ]N	_____	[ ] Renal Failure	_____	[ ] Y [ ] N	_____
[ ] Diabetes	_____	[ ]Y [ ] N	_____	[ ] Seizure Disorder	_____	[ ] Y [ ] N	_____
[ ] Eczema	_____	[ ] Y [ ] N	_____	[ ] Stroke	_____	[ ] Y [ ] N	_____
[ ] Enlarged Prostate	_____	[ ] Y [ ] N	_____	[ ] Thyroid Disorder	_____	[ ] Y [ ] N	_____
[ ] Gout	_____	[ ] Y [ ] N	_____	[ ] Urinary Tract Infections	_____	[ ] Y [ ] N	_____
[ ] Hearing Impairment	_____	[ ] Y [ ] N	_____	[ ] Other: _____	_____	[ ] Y [ ] N	_____
[ ] High Blood Pressure	_____	[ ] Y [ ] N	_____	_____	_____	[ ] Y [ ] N	_____
[ ] High Cholesterol	_____	[ ] Y [ ] N	_____	[ ] Adopted	_____		

[ ] Inflammatory

Social History:

Children? [ ] Y [ ] N How Many? _____ **(Women Only)** Date of Last Menstrual Period _____

TOBACCO: Do You Use Tobacco [ ] Y [ ] N Type of Tobacco _____ Amount per day: _____ How Long: _____
Current Every Day Smoker [ ] Y [ ] N Current Sometimes Smoker [ ] Y [ ] N Former Smoker [ ] Y [ ] N
When Quit? _____ Have you Tried To Stop [ ] Y [ ] N Second Hand Smoke Exposure [ ] Y [ ] N

CAFFEINE: [ ] Y [ ] N _____/_____ Amount of Caffeine per Day _____

ALCOHOL: Drinks Alcohol [ ] Y [ ] N Formerly Drank [ ] Y [ ] N Type: _____ Frequency: _____
Amount: _____ Last Drink: _____

IMMUNIZATIONS: Tetanus [ ] Y [ ] N Date: _____ Influenza [ ] Y [ ] N Date: _____
Pneumonia [ ] Y [ ] N Date: _____ H1N1 [ ] Y [ ] N Date: _____

Review of Systems:

Please mark Yes or No if you are currently experiencing any of the following symptoms.
Additional information may be added in the NOTES section at the bottom of the page.

Constitutional:
[ ]Y [ ] N Chills
[ ] Y [ ] N Fever
[ ] Y [ ] N Weight Loss
Other _____

Cardiovascular:
[ ] Y [ ] N Chest Pain
[ ] Y [ ] N Heart Murmur
[ ] Y [ ] N Palpitations
[ ] Y [ ] N Varicose Veins
Other _____

Genitourinary:
[ ] Y [ ] N Burning with Urination
[ ] Y [ ] N Erectile Dysfunction
[ ] Y [ ] N Blood in Urine
[ ] Y [ ] N Urinary Frequency
[ ] Y [ ] N Urinary Incontinence
[ ] Inability to Urinate
Other _____

Metabolic/Endocrine:
[ ] Y [ ] N Cold intolerance
[ ] Y [ ] N Excessive Thirst
[ ] Y [ ] N Fatigue
[ ] Y [ ] N Male Breast Enlargement
[ ] Y [ ] N Heat Intolerance
[ ] Y [ ] N Hot Flashes
Other: _____

Musculoskeletal:
[ ] Y [ ] N Arthritis
[ ] Y [ ] N Back Pain
[ ] Y [ ] N Joint Pain
[ ] Y [ ] N Neck Pain
Other: _____

HEENT:
[ ] Y [ ] N Blurred Vision
[ ] Y [ ] N Double Vision
[ ] Y [ ] N Ear Infection
[ ] Y [ ] N Eye Pain
[ ] Y [ ] N Hearing Loss
[ ] Y [ ] N Sinus Infection
[ ] Y [ ] N Sore Throat
Other: _____

Gastrointestinal:
[ ] Y [ ] N Abdominal Pain
[ ] Y [ ] N Blood in Stool
[ ] Y [ ] N Constipation
[ ] Y [ ] N Heartburn
[ ] Y [ ] N Loss of Appetite
[ ] Y [ ] N Nausea
[ ] Y [ ] N Vomiting
Other: _____

Reproductive – Male:
[ ] Y [ ] N Penile Discharge
[ ] Y [ ] N Sexual Dysfunction
Other: _____

Reproductive – Female:
[ ] Y [ ] N Breast Lumps
[ ] Y [ ] N Breast Pain
[ ] Y [ ] N Vaginal Discharge
Other: _____

Neurological:
[ ] Y [ ] N Difficulty Walking
[ ] Y [ ] N Headaches
[ ] Y [ ] N Memory Loss
[ ] Y [ ] N Seizures
[ ] Y [ ] N Tremors
Other: _____

Hematologic/Lymphatic:
[ ] Y [ ] N Easy Bleeding
[ ] Y [ ] N Lymphadenopathy
[ ] Y [ ] N Spontaneous Bruising
Other: _____

Respiratory:
[ ] Y [ ] N Chronic Cough
[ ] Y [ ] N Shortness of Breath
[ ] Y [ ] N Know TB Exposure
[ ] Y [ ] N Wheezing
Other: _____

Integumentary:
[ ] Y [ ] N Contact Allergy
[ ] Y [ ] N Hives
[ ] Y [ ] N Itching Skin
[ ] Y [ ] N Rash
Other: _____

Psychiatric:
[ ] Y [ ] N Anxiety
[ ] Y [ ] N Depression
[ ] Y [ ] N Insomnia
Other: _____

Immunologic:
[ ] Y [ ] N Asthma
[ ] Y [ ] N Food Allergies
Other: _____

Medications or Other Concerns: _____

_____

_____

_____