INTEGRATED HEALTH ASSOCIATES

PATIENT INTAKE FORM

PLEASE LET US KNOW IF YOU NEED ASSISTANCE COMPLETING THIS FORM

The information you provide on this form is confidential and will be used solely for your evaluation, treatment, billing, and healthcare operations in accordance with HIPAA.

DEMOGRAPHIC DATA TODAY'S DATE: _____

Full Name: _____

Preferred Name / Nickname: _____

Date of Birth: _____ Age: _____ Male / Female (circle)

Address: _____ City: _____

State: _____ Zip: _____

Preferred Phone: _____ Email: _____

Parent's Full Name (if a minor): _____

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Work Status: Full-time Part-time Self Employed Homemaker Retired Student

(circle one) Unemployed/seeking work Disability

Occupation (if appropriate): _____ Employer: _____

HEALTH HISTORY

Primary Care MD: _____ Phone: _____

Other MD's? Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Have you been diagnosed with: (circle all appropriate)			
	high blood pressure	disc herniation	osteoporosis
	heart disease	stenosis	carpal tunnel
	diabetes	spondylolisthesis	thyroid disorder
	cancer	sciatica	asthma
	stroke	stenosis	anxiety
	arthritis	degeneration	depression

other: _____

When did your symptoms start?: _____

What were you doing when you first experienced your symptoms? (bending, lifting, etc.) Please be specific:_____

_____

_____

_____

Describe your pain:	sharp	throbbing	other: _____
(circle all appropriate)	dull	tingling/numbness	
	aching	shooting	
	burning	stiffness	

What makes your symptoms worse? _____

What have you tried to help ease your symptoms? _____

Has this worked? Yes/No (circle)

Have you had this problem before? Yes / No (circle)

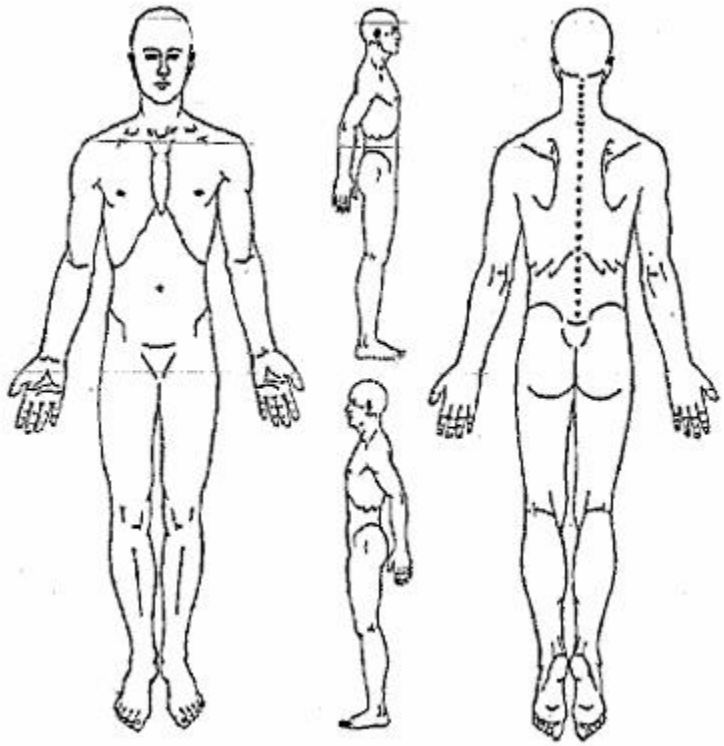
If yes, explain:_____

PAIN DIAGRAM

On the diagrams below, mark where you are experiencing pain right now. Use the letters below to indicate the type and location of what it is you are feeling.

A – Ache B – Burning N – Numbness P – Pins and needles S – Stabbing

O - Other



PAIN SCALE – Rate the severity of your pain by **circling ONE NUMBER** on the following scale:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Possible Pain

Is what you are experiencing due to:
(please circle)

work related injury
auto accident
sports injury
fall, when? _____
gradual onset, approximate onset _____
sudden onset, when? _____
none of the above

What other symptoms are you experiencing?:
(circle all that apply)

blurred vision	buzzing/ringing in the ears
cold feet/hands	easily cold
digestive issues	stomach upset
fatigue	loss of balance
difficulty walking	dizziness
shortness of breath	loss of concentration
muscle jerking	muscle weakness
vision problems	light sensitivity
hearing problems	joint pain
chronic headaches	migraines

other: _____

How are these symptoms affecting your activities of daily living? Please explain: _____

_____

Surgeries / Hospitalizations:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Current medications, including all vitamins and supplements:

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Allergies (medication, food, environmental): _____

Family medical history:
mother: _____
father: _____
siblings: _____
significant family illnesses, please describe: _____

_____

LIFESTYLE HISTORY

Does your daily routine require you to lift weight regularly? Yes/No (circle)

If yes, 10# 20# 30# 40# 50# >50# (circle)

Smoking:	never	former	currently	
Alcohol Consumption:	none	occasionally	weekly	daily
Exercise:	rarely, if ever	1-2x/week	3-5x/week	daily

Hours of sleep per night: _____ Do you wake up at night due to pain? Yes/No (circle)

GOALS

What would like to achieve through conservative treatment? (circle all that apply)

pain relief
improved mobility
better posture
increased activity
sports performance
wellness/maintenance
other, please explain:

_____

_____

_____

Whom can we thank for your referral to our office? _____

AUTHORIZATION TO TREAT / INFORMED CONSENT

I, the undersigned patient, hereby authorize Dr. John Livingston and his staff to administer such treatment as is necessary, and to perform services and/or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode(s) of treatment which were explained to me, and I give my informed consent for Dr. John Livingston to treat me. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient signature: _____ Date: _____

Guardian signature: _____ Date: _____