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Confidential Health Intake

TODAY'S DATE:________________________ **Referred by/learned about me from:**________________________
Title: Ms—Mr—Mrs—Miss—other (list)_______________ **Gender**____________________
First Name:___________ **M.I.**___ **Last Name:**__________ Preferred suffix/credentials (*list):*_______________

Address:___________________**Apt/Suite:**__________**City, State & Zip**____________________________

Primary Phone: (____**)**_______________c-w-h **Other Phone: (**_____**)**___________c-w-h
Email(s): ____
Occupation: ____ **Date of Birth:**____/_____/_____

Emergency Contact Name ______________________**&Number(s):**__________________________________

Relationship to you (friend, type of relative, significant other, etc.): ___________________________________

Please list your reasons for seeking therapy today (CHIEF COMPLAINT):_______________________________

____**How does this LIMIT you (***if applicable***)?**________

____

WHEN did it start?___________________**HOW did this happen/begin?**______________________________

What makes this issue *worse*? Sitting – standing – lying – walking – coughing/sneezing – heat - cold

Other (list)__________________________ **WHAT TIME of day is it *worst*?** _____________________________

What makes it *better*? Sitting – standing – lying – walking – coughing/sneezing – heat – cold -medication

Other (list)__________________________**WHAT TIME of day is it *best*?** ______________________________

What kind of health care providers do you currently see, including for this complaint? List all:

(e.g. Family Practice provider, OB/GYN, Osteopath, Chiropractor, Herbalist, Psychotherapist, etc.)__________

____

Please list any regular/usual physical activities: ____

Medications, herbs, other supplements you are taking:____

How do you relieve pain (medications, other)?____

Have you used any of these (pain relievers) today?______ **If so, state which:**_________________________

Please list any ALLERGIES/SENSITIVITIES and reaction, if known, including LATEX, medications, foods,

environmental: ____

Could you be pregnant? **Y/N** **# of months?** _________

Side of body you use most? LEGS/FEET (*right/left/both***):** _______ **ARMS/HANDS(***right/left/both***):** _______

CIRCLE/LIST reports or tests done recently. *Bloodwork - Radiograph (x-ray film) - MRI - C/T scan*

Nerve Conduction Test - Other _______________ *- Other*________________ *- Other*_________________

Health History

1. **Please check if <u>YOU</u> currently *<u>or ever in the past</u> experienced or were treated for* any of the following (please add dates and details where appropriate).**
2. **If a <u>FAMILY MEMBER</u> has had this, please mark with "F".**

__accidents (car, fall, other)
____
____
__ arthritis
____
__ back pain
__ blood clots/aneurism
__ bone/joint condition or Infection _____________
__ breathing/lung issues (asthma, sleep apnea, any difficulty breathing, lung conditions)___________
____
__ bursitis_____________
__ cancer/ malignancies
____
__ chest pain/ tightness
__ cold hands/ feet
__ clinical depression, anxiety, other mental health issues
__ diabetes___________
__ easy bruising/bleeding
__ edema/ swelling

__falls_______________
__ foot problems
__ frequent headaches
__ hand/wrist issues
__ heart attack/disease
__ Hepatitis (type) _____
__ high/low blood pressure
__ hyperglycemia
__ joint problems (other than listed)_______________
____
__ knee pain/ issues
__ kidney or liver issues/treatment/disease
__ lymph node removal,
__ lymph edema
__ Multiple Sclerosis
__ muscle spasm
__ rheumatologic condition (lupus)
__ sciatica
__ scoliosis/spine conditions
__ seizures
__ shoulder pain/issues

__ sleep disturbances/ issues
__ skin condition/infection/ rash/ open sores
__ stroke
__ surgery (list below)
__ tendon problems
____
__ tingling/pain/numbness in extremities___________
__ torn cartilage/ ligament
__ therapy/treatment (p.t., chemo/radiation, eastern medicine, etc.)
____
__ Tuberculosis
__ varicose veins
__ HIV or other infectious disease
__ other contagious disease
__ other:_____________
____

Do you:
__ *Smoke?* ___________
__ *Drink alcohol?* _____

Have you recently had/felt (check all that apply):

__ Dizziness
__ Fever
__ Fatigue
__ Numbness/strange sensations
__ Nausea/Vomiting
__ Confused/Poor Memory or Understanding
__ Malaise (generally feeling "blah")
__ Weight loss/gain
__ Weakness

Do you use, wear <u>or</u> have you ever been prescribed (check all, list brief reason/date):

__ orthotics ________________________________
__ prosthetic devices ___________________________
__ surgical hardware ___________________________
__ assistive devices ___________________________
__ hearing aids/corrective lenses __________________
__ mesh/other for hernia repair _______________
__ pump (and reason) _____________________
artificial joint __________________________
__ pacemaker/stent/vascular device_____________
__ other implants___________________________

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Please give __details__ about any recent and past injuries, surgeries, trauma, other health issues that you are or have been monitored for, including those checked on previous page:_______________________________________

____

Is this your first therapy session? Y / N   If "no": *What did you like? Dislike? How did it help you?* __________

____

-- *It bothers me most in the areas marked below*.

-- Draw lines between different areas if they are ever connected.

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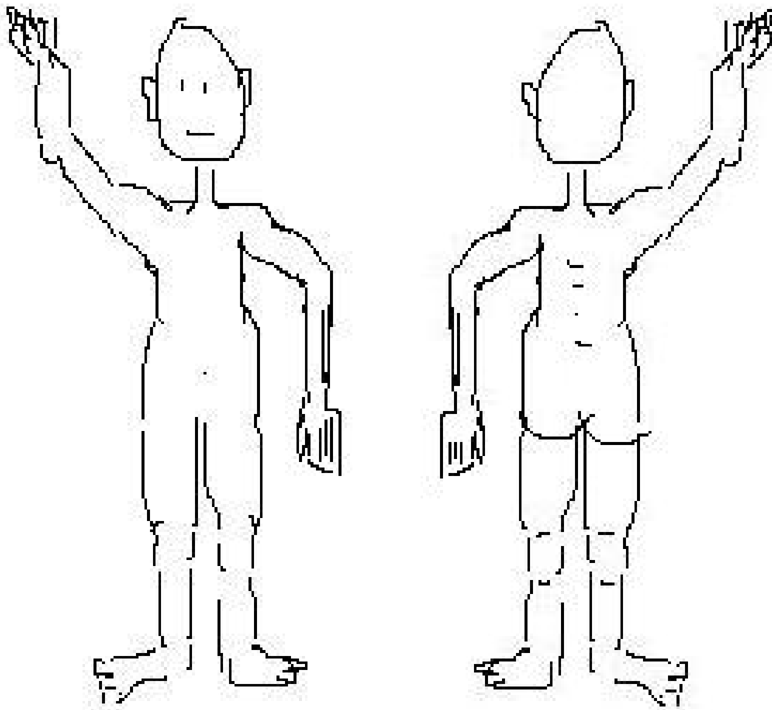

Use words to describe, including:

"numb" "tingle" "cold"

"hot/burning" "pressure"

[***your other words***]

__PAIN__: "sharp" "shooting" "ache" "deep" "surface" "throb" "wave-like"

[***your other descriptions***]

PAIN RATING (if applicable):

__TODAY__:

0(none) – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10(worst you can imagine)

__BEST__:

0(none) – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10(worst you can imagine)

__WORST__:

0(none) – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10(worst you can imagine)

Do you feel you are safe?_____________________________ **Has anyone tried to harm you?** ______________

Is there anything else you would like to share with or ask of me in confidence?________________________

____

How do you: Experience happiness? Find groundedness & balance? De-stress? ________________________

____

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