Patterns of Life

Pain Relief & Prevention

203-254-0820

Client Intake Form

First Name*:

Last Name*:

Occupation:

Address 1*:

Address 2:

City*:

State*:

Zip*:

Daytime Phone #*: - -

Evening Phone #*: - -

Email:

Date of Birth:

Gender*

Referred by:

(No personal information will be shared with other parties)

Please answer all of the following questions. If one does not apply, please put n/a.

1. Major complaint or condition you want to improve*:

2. When did you first notice major complaint(s)?*:

3. What brought it on?*:

4. What activities aggravate the condition?*:

5. Is this condition getting progressively worse?*: ◯ yes ◯ no

Please explain:

6. Does this condition interfere with **Work**?*: ◯ yes ◯ no

Sleep?*: ◯ yes ◯ no

Daily Routine?*: ◯ yes ◯ no

Please explain:

7. What have you done to get relief?*:

8. Has there been a medical diagnosis?*: ◯ yes ◯ no

If so, by whom?:

Please explain:

9. Have you had X-rays taken?*: ◯ yes ◯ no

If yes, by whom?:

10. Are you now under medical/therapeutic treatment?*: ◯ yes ◯ no

If yes, for what condition?:

11. List any medications (including aspirin) and nutritional supplements you are taking*:

12. Describe the exercise activities you do (include frequency)* :

13. List other therapies you receive*:

14. Please list (date and description) any accidents or operations*:

15. Please list any additional comments regarding your health and well-being*:

In Case of Emergency, Please Notify:

Name: Telephone:

Relationship:

Please complete the Health History on the next page.

Health History

(Check all that apply)

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Strains/sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Chest, ribs, abdominal pain
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease

☐ Other:

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other:

Reproductive System

- ☐ PMS
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- Pregnancy: ☐ Current ☐ Previous
- ☐ Fertility concerns
- ☐ Prostate problems

Circulatory & Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Vericose Veins
- ☐ Pressure sores
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphdema

☐ Other:

Nervous System

- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury

☐ Other:

Health History

(Continued)

Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/ bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other:

Other

- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Bladder infection
- ☐ Burning upon urination
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Eating disorder
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Drug use
- ☐ Alcohol use
- ☐ Nicotine use
- ☐ Caffeine use
- ☐ Infectious disease (please list)
- ☐ Other congenital or acquired disabilities (please list)

Please list any additional comments regarding your health and well-being:

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client Signature*:

Date*: (mm/dd/yyyy)

(If emailed, signature & date will be obtained when you come into our office. If printed, please sign and bring with you to our office.)