Discover Wellness Intake Form

Date: _____ **Address:** _____

First Name: _____ **City:** _____

Last Name: _____ **State:** _____

Called Name: _____ **Zip Code:** _____

Birthday: _____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____

How did you hear about our office? _____

Briefly explain the reason for your visit today. _____

_____

_____

Are you experiencing any of the following symptoms: (Please circle if yes)

Neck Pain	**Shoulder Pain**
Upper Back Pain	**Elbow Pain**
Pain Between Shoulders	**Wrist/Hand Pain**
Middle Back Pain	**Hip Pain**
Lower Back Pain	**Knee Pain**
Sciatica	**Ankle/Foot Pain**
Headaches	**Sinusitis/Allergies**

Other symptoms: _____

Have you been treated for your condition(s) before today? **YES / NO**

If yes, what was done? _____

_____

Are you currently taking any medication(s)? **YES / NO**

If yes, please list medication(s) and dose: _____

_____

_____

Please continue on back ---->

Family History

Does anyone in your immediate family (mother/father/brother/sister) have any of the following:

Condition	Family Member
Arthritis	_____
Heart Disease	_____
Diabetes	_____
Cancer	_____
Other: _____	_____

Physical History

Height: _____ft _____ in

Weight: _____lbs

Last known Blood Pressure Reading: _____ / _____ mmHg

Please list any Allergies you have: _____

_____

Have you ever smoked cigarettes? YES / NO

Do you currently smoke cigarettes? YES / NO If yes, how much? _____

If you used to smoke cigarettes, when did you quit? _____

Please list any surgeries and dates they were performed: _____

_____

_____

I certify that the information I have provided is complete to the best of my knowledge, and that with my signature I am consenting to treatment.

_____

Patient (or Guardian's) Signature **Date**