



Patient Intake

Today's Date: __/__/__

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Marital Status _____ Spouse Name _____ Home Phone _____ Cell Phone _____

Email Address: _____ Occupation _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about our office?

Drive By Walk-In Internet Referral (Please tell us who) _____ Other: _____

Health Insurance Information

Primary Insurance _____ Policy Holder's Name _____ DOB _____

Policy Holder's Relationship to Patient _____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: Auto Injury Work Injury Slip and Fall Other Accident (describe below)

Date of Accident _____ Place (City/State) _____

Auto/Work Insurance Company _____ Insured's Name and DOB _____

If Auto Injury, have you reported the accident to your insurance company? No Yes Claim # _____

If Work Injury, have you reported the accident to your supervisor/boss? No Yes Claim # _____

If Slip and Fall or Other Type of Injury, please describe: _____

Do you have an Attorney for your Auto or Work Comp. injury Yes No

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your worst complaint: _____ How long have you had it: _____

How did it start? _____ A) Is it: Improving Worsening Staying the Same B) Is it: Mild Moderate

Severe C) What worsens it: General activity Moving Wrong Bending Lifting Walking Sports Getting up from a chair

Using a computer/desk work Other: _____ D) What makes it better: Rest General Activity Ice Packs

Heating Pad OTC Meds Rx Meds Massage Chiropractic Other: _____ E) Is it worse in the: AM PM

After day wears on Steady Off and on F) Is the symptom: Dull and Achy Tight and Stiff Sharp and Stabbing

Numb and Tingly Shooting Burning Cramping

II. Please list your 2nd worst complaint: _____ How long have you had it: _____

How did it start? _____ A) Is it: Improving Worsening Staying the Same B) Is it: Mild Moderate

Severe C) What worsens it: General activity Moving Wrong Bending Lifting Walking Sports Getting up from a chair

Using a computer/desk work Other: _____ D) What makes it better: Rest General Activity Ice Packs

Heating Pad OTC Meds Rx Meds Massage Chiropractic Other: _____ E) Is it worse in the: AM PM

After day wears on Steady Off and on F) Is the symptom: Dull and Achy Tight and Stiff Sharp and Stabbing

Numb and Tingly Shooting Burning Cramping

Current Health

- Name and phone number of family doctor: _____
- List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc.):

- If you are currently taking any prescription or nonprescription medications, please list them below with dosages:
Medication: _____ Dose: _____ Medication: _____ Dose: _____
Medication: _____ Dose: _____ Medication: _____ Dose: _____
- Please list any medications you are allergic to: _____
- Please indicate your height and weight _____

Health History

- List any operations, surgeries or medical procedures:
Date: _____ Procedure: _____ Date: _____ Procedure: _____
Date: _____ Procedure: _____ Date: _____ Procedure: _____
- If you have ever had in the past or currently have any serious illnesses or injuries, please list:
Date: _____ Condition: _____ Date: _____ Condition: _____
Date: _____ Condition: _____ Date: _____ Condition: _____
- Any current loss of bowel or bladder control: Yes No Any current seizures, paralysis, speech, vision problems: Yes No
- Any unexplained recent weight loss: Yes No Current fever: Yes No Current nutritional problems: Yes No
- Please list any significant family illnesses _____
- Have you had spinal X-Rays within the past 5 years? If yes, when and where _____
- Do you have a pacemaker? Yes No If yes, please ALERT our doctor and/or chiropractic assistant
- Do you have any blood/lymph disorders? Yes No If yes, please list _____
- Do you have osteoporosis or rheumatoid arthritis? Yes No
- Please list any other electrical device that you currently wear _____
- Please select one: I have never smoked Former smoker Current smoker, if so how much: _____pk./day _____pk./wk.
- Please select one: I don't drink alcohol Rarely drink Social drinker Heavy drinker (_____oz. per day/week)
- Have you ever had chiropractic care Yes No If yes, last date of treatment _____ By whom: _____
- Similar or difference condition: _____ Results: _____

What are your overall expectations from your treatment with our doctor: _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to order x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

• **WOMEN ONLY** I hereby declare that to the best of my knowledge I am I am not pregnant. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

Patient Signature _____

(Parent/Guardian signature if under 18 years of age)



Authorization to Discuss Medical Information

Performance Medicine and Sports Therapy is committed to quality patient care and we are advocates of maintaining patient confidentiality. Our policy is to speak only to patients and/or guardians personally in regards to their confidential medical information. Also, we will not leave any confidential medical information on a voice mail system without permission to do so. By filling out this form and signing below, you are giving the physicians and staff at PMST permission to communicate more detailed information to other individuals and/or your voicemail. Examples included but are not limited to; your lab and test results, information about your condition, prescription refills or changes, appointment scheduling or insurance details. ***Performance Medicine and Sports Therapy will keep this consent form in your chart. This form will be effective until otherwise notified by the patient with a written request.***

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

I _____ (INI) authorize the physician and staff at Performance Medicine and Sports Therapy to leave a detailed voice message regarding my medical care at the following phone number(s). You may write specific instructions below.

Patient Phone #1 _____

Instructions: _____

Patient Phone #2 _____

Instructions: _____

I _____ (INI) authorize the physician and staff at Performance Medicine and Sports Therapy to speak with the following individual(s) about my medical care. You may write instructions below.

Name: _____ Relationship: _____ Date: _____

Instructions: _____

Name: _____ Relationship: _____ Date: _____

Instructions: _____