Osteopathic Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/Postal Code _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any recent surgeries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Primary Complaint:

Secondary Complaints:

Pain Scale (Circle One):
1-2-3-4-5-6-7-8-9-10

Since When?:

How Often?:

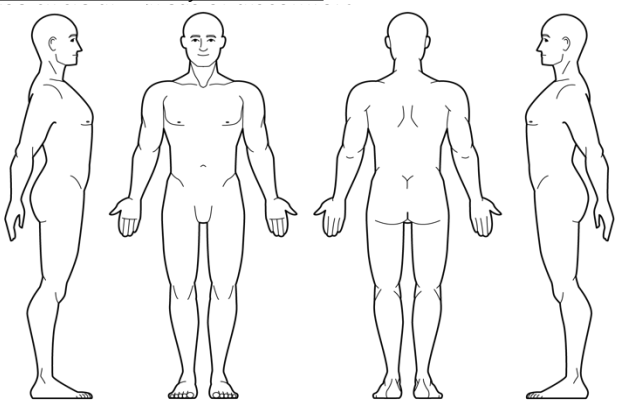
How did it happen? (Trauma/Repetitive Strain/Unknown):

Is it getting better, staying the same, or worst?

Past Treatment History:

Have you had any MRI, X-Ray, CT, Ultrasound. Bone Density, Blood Work? (Please add date of test):

Please Shade or Draw In Any Areas of Pain:



By signing below, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform my practitioner if any of the above information changes at any time.

Client Signature: _____ *Date* _____
(Or Acting Guardian)

Practitioner: _____ *Date* _____