INTAKE FORM

PATIENT INFORMATION

Date: ______________ *Preferred Language:* ______________ ☐ *Interp.*

Patient Name: ________________________________ Birthdate: ____________ Age: ______
FIRST, MIDDLE, LAST (MM / DD / YYYY)

Nickname: ______________________ *(the name you prefer to be called, if different)* Gender: ☐ MALE ☐ FEMALE

If the patient is a **CHILD under 18 years old**, enter the child's legal parent/s or guardian information:

Relationship	Name	Birthdate	Phone Number
☐ Father			
☐ Mother			
☐ Guardian/Foster Parent			

Who does child live with? ☐ Father ☐ Mother ☐ Both ☐ Guardian/Foster Parent ☐ Grandparent ☐ Sibling ☐ ____________

Patient Address: ________________________________

City / State / Zip: ________________________________

Phone Number: ______________ E-Mail Address: ______________

Marital Status: ☐ SINGLE ☐ MARRIED / DOMESTIC PARTNER ☐ DIVORCED ☐ WIDOWED *Number of Children:* ______

Emergency Contact: ***NAME:*** ______________________ ***PHONE:*** ______________

Employment Status: ☐ EMPLOYED FULL TIME ☐ EMPLOYED PART TIME ☐ UNEMPLOYED ☐ RETIRED ☐ HOMEMAKER ☐ STUDENT

Your Occupation: ______________ Your Employer: ______________

Work Address: ______________ Work Phone: ______________

If you are a STUDENT, name of School: ______________ ☐ Full Time ☐ Part Time

Your Primary Doctor: ______________ Phone: ______________

Your Attorney (if any): ______________ Phone: ______________

Who referred you to our clinic? ______________

Is your condition related to: ☐ an **AUTO ACCIDENT**? ☐ a **WORK-RELATED** injury or cause? ☐ another kind of **INJURY**?

If not an injury, did it start: ☐ GRADUALLY? *(slowly over time)* ☐ SUDDENLY? *(symptoms just appeared)* ☐ CHRONIC? *(had for a long time)*

WHEN did your injury occur or other condition begin? **Enter date:** ______________ *(enter approximate date if exact date unknown)*

WHERE did your injury occur or other condition begin? **Enter location:** ______________

Describe your symptoms or condition: ________________________________

____

____

Have you ever had the same or similar symptoms or condition? ☐ NO ☐ YES If yes, when? ______________

If yes, describe: ________________________________

____

PATIENT INFORMATION

Date: ______________________

Enter the names of any other healthcare providers you have seen for this injury or condition:

Name of Healthcare Provider	Type of Practice *(specialty)*	Date of Last Visit

Please list all medications you are taking now, including over-the-counter medicines *(such as Tylenol, Advil, Ibuprofen, Aspirin)* :

____

(Please note that we must have a list of all medications you are taking. You may attach a separate sheet if more space is needed)

PAST ACCIDENTS, INJURIES, SURGERIES, ILLNESS

List ALL auto accidents, work injuries, sports injuries, other injuries, surgeries and major illnesses you have ever had in the past. *Tell us what body area/s were injured or had surgery (describe the injury or illness), the month & year for each one (if you're not sure, enter your best guess), and tell us whether you recovered fully and if not, what problem/s remain.*

Auto Accident?	Work Injury?	Other Injury?	Surgery?	Serious Illness?	What body area/s & condition/s were involved?	Month/Year	Did you recover fully? *(If not, enter details)*
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			

Have you ever had any of the following conditions?

☐ Arthritis	☐ Backaches	☐ Digestive Disorders	☐ Heart Trouble	☐ Neuritis
☐ Anemia	☐ Cancer	☐ Dizziness	☐ Hernia	☐ Numbness
☐ Asthma	☐ Diabetes	☐ Headaches	☐ Nervousness	☐ Sinus Trouble

WOMEN'S HEALTH - *For Women Only*

Date of Last Menstrual Period ______

Are you pregnant? ☐ No ☐ Yes ☐ Unsure If yes, what is your due date? ____________

PATIENT CERTIFICATION

I certify that the information I give on this form and during my examination is true, correct and complete to the best of my knowledge. I will not hold the doctor nor the clinic responsible for any errors or omissions that I may have made in my answers. I understand and agree that the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature ____________ Personal Representative's Signature ____________ Date Signed ____________

Description of personal representative's authority to act for the patient. ____________ Personal Representative's Name *(Printed)* ____________ *Staff Witness* ____________

DOCTOR'S NOTES: ____

REVIEWED BY:
Doctor's Signature: ____________

- ☐ Joseph A. Graffeo, DC
- ☐ Joseph F. Graffeo, DC
- ☐ Michael T. Malone, DC
- ☐ Kelley Silon, DC