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: _____

_____

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

INTAKE FORM

WORK INJURY QUESTIONNAIRE

Date: _____ Patient Name: _____

WORK INJURY DETAILS

Date of Work Injury: _____ Time of Work Injury: _____ AM / PM

Where did the work injury happen? _____

_____

How did the work injury happen? _____

_____

Did you keep working that day after you were injured? ☐ Yes ☐ No If Yes, how long did you work? _____

Did you go back to work the next day (or next scheduled work period)? ☐ Yes ☐ No If Yes, why? _____

Did you report this work injury? ☐ Yes ☐ No If Yes, on what date did you report it? _____

Who did you report it to? _____ What is their position? _____

Did your employer fill out a work injury report form *(Form 801)* ? ☐ Yes ☐ No If Yes, do you have a copy? ☐ Yes ☐ No

Were there any witnesses to your work injury? ☐ Yes ☐ No If Yes, enter witness name(s):

Witness Name(s): _____

Employer's Legal Business Name (if different): _____

Employer's Address: _____ Phone: _____

Your job description: _____ How long have you worked there? _____

Supervisor's Name and/or Title: _____

As a result of the work injury were you rendered unconscious? ☐ Yes ☐ No If yes, how long were you unconscious? _____

Did you get any bleeding cuts or bruises? ☐ Yes ☐ No If yes, where were they? _____

Did you go to the hospital or see another doctor for your work injury? ☐ Yes ☐ No If yes, when? _____

How did you get there? ☐ I drove myself ☐ Someone else drove me ☐ An ambulance took me ☐ Other: _____

Hospital or doctor's name: _____

(enter the name/s of all hospitals and/or doctors you have seen because of your work injury)

Have you been x-rayed since the work injury? ☐ Yes ☐ No Have you had an MRI since the work injury? ☐ Yes ☐ No

Have you lost any days of work because of the work injury? ☐ Yes ☐ No If yes, how many days have you lost? _____

PATIENT CERTIFICATION

I certify that the information I give on this form and during my consultation 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.

Patient Signature: _____ Date Signed: _____

DOCTOR'S NOTES: _____

_____

_____

_____

REVIEWED BY:

Doctor's Signature: _____

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