Patient Intake Form

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ ☐ **Male** ☐ **Female**

Address: _____ **Height:** _____

_____ **Weight:** _____

_____ **Heaviest Weight:**_____ **When:** _____

Phone #: Home: _____ **Work:** _____

Cell Phone: _____ (*Please circle your preferred contact number*)

E-mail address: _____

Occupation: _____ **Employer:** _____

Marital status: **Single** **Married** **Widowed** **Divorced** **Separated** **Domestic Partner**

How Did You Hear About Us:_____

(If referral please write name of person who referred you to us.)

Mark a check in the column under (C) for current problems or (P) for past problems:

General

C	P	
☐	☐	Allergies
☐	☐	Depression
☐	☐	Dizziness/Fainting
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Headaches
☐	☐	Loss of sleep
☐	☐	Mental illness
☐	☐	Nervousness
☐	☐	Tremors
☐	☐	Weight loss / gain

Muscle / Joint

☐	☐	Arthritis/Rheumatism
☐	☐	Hernia
☐	☐	Spinal Surgery
☐	☐	Bursitis
☐	☐	Foot trouble
☐	☐	Muscle weakness
☐	☐	Low back pain
☐	☐	Neck pain
☐	☐	Mid back pain
☐	☐	Joint pain

Skin

C	P	
☐	☐	Boils
☐	☐	Bruise easily

Skin (*Cont.*)

C	P	
☐	☐	Dryness
☐	☐	Hives or rash
☐	☐	Itching
☐	☐	Varicose veins

Eye, Ear, Nose & Throat

☐	☐	Frequent Colds
☐	☐	Deafness
☐	☐	Ear ache
☐	☐	Eye pain
☐	☐	Gum trouble
☐	☐	Hoarseness
☐	☐	Nasal obstruction
☐	☐	Nose bleeds
☐	☐	Ringing of the ears
☐	☐	Sinus infection
☐	☐	Sore throat
☐	☐	Vision problems

Respiratory

☐	☐	Chest pain
☐	☐	Chronic cough
☐	☐	Difficulty breathing
☐	☐	Hay fever
☐	☐	Shortness of breath
☐	☐	Spitting up phlegm
☐	☐	Spitting up blood
☐	☐	Wheezing

Gastrointestinal

C	P	
☐	☐	Abdominal pain
☐	☐	Bloody or tarry stool
☐	☐	Colitis / Crohn's
☐	☐	Colon trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficult digestion
☐	☐	Diverticulitis/losis
☐	☐	Bloated abdomen
☐	☐	Heart Burn
☐	☐	Excessive hunger
☐	☐	Gallbladder trouble
☐	☐	Hernia
☐	☐	Hemorrhoids
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Painful defecation
☐	☐	Pain over stomach
☐	☐	Poor appetite
☐	☐	Vomiting
☐	☐	Vomiting of blood

Genitourinary

☐	☐	Bed-wetting
☐	☐	Bladder infection
☐	☐	Blood in urine

Genitourinary (*Cont.*)

C	P	
☐	☐	Kidney infection
☐	☐	Kidney stones
☐	☐	Prostate trouble
☐	☐	Stress incontinence urination
☐	☐	Overnight more than 2 times
☐	☐	Decreased flow/force
☐	☐	Painful urination
☐	☐	Urgency to urinate

Cardiovascular

☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Hardening of the arteries
☐	☐	Irregular pulse
☐	☐	Pain over heart
☐	☐	Palpitations
☐	☐	Poor circulation
☐	☐	Rapid heart beat
☐	☐	Slow heart beat
☐	☐	Swelling of ankles

Women Only

☐	☐	Hot flashes
☐	☐	Lumps in breast
☐	☐	Menopause
☐	☐	Vaginal discharge

Women Only

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: _____ Length of cycle: _____

Date of 1st day of last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____

☐ normal ☐ abnormal

Date of last mammogram: _____

☐ normal ☐ abnormal

Please list any medication you are currently taking:

_____

_____

_____

_____

_____

_____

_____

Check any of the conditions you have or have had:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Cancer
☐ Cold sores
☐ Concussions
☐ Diabetes
☐ Dislocations
☐ Eczema
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Goiter
☐ Gout
☐ Heart burn
☐ Heart disease
☐ Hepatitis
☐ High cholesterol
☐ HIV/AIDS
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Numbness/tingling
☐ Pace maker
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

When did your symptoms appear? _____ Is it getting worse? ☐ yes ☐ no ☐ unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of Pain:
☐ Sharp ☐ Dull ☐ Throbbing
☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling ☐ Numbness
☐ Aching ☐ Shooting ☐ Other

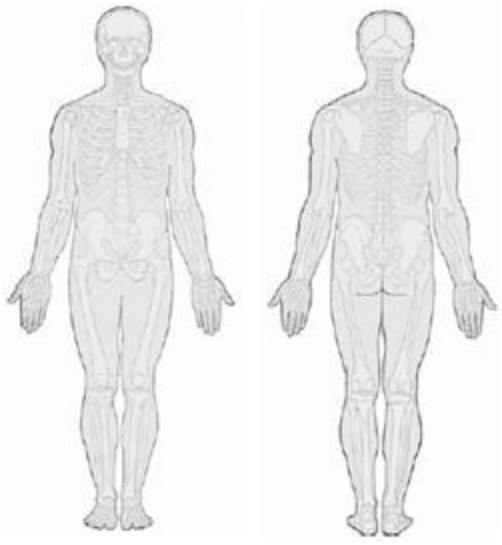
How often do you get this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Daily Routine
☐ Recreation ☐ Sleep

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Past health history

Have you...	Yes	No	If yes, explain briefly
..been hospitalized in the last 5 year?	☐	☐	_____
..had any mental disorders?	☐	☐	_____
..had any broken bones?	☐	☐	_____
..had any strains or sprains?	☐	☐	_____
..ever used orthotics?	☐	☐	_____
..had surgery?	☐	☐	_____

How is most of your day spent? ☐ Standing ☐ Sitting ☐ Other: _____
Do you take minerals, herbs or vitamins? ☐ Yes ☐ No
How old is your mattress? _____
Do you have or have you had dental amalgams? ☐ Yes ☐ No

Habits	None	Light	Mod	Hvy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soda	☐	☐	☐	☐
Salty Food	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history ***If any blood relative has had any of the following conditions, please check and indicate which relative(s):***

☐ Alcoholism	☐ Cancer	☐ High blood pressure
☐ Anemia	☐ Diabetes	☐ High cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed easily	☐ Heart disease	☐ Thyroid disease

Please list any allergies you may have (medications/foods/environmental): _____
_____

Family Physician *(Name and City)***:** _____

Date of last physical exam: _____

Do you have any other health issues or concerns that our staff should be made aware of? _____
_____

As a courtesy and with respect for you, we set aside a specific day and time for your appointment. In the event that you cannot keep your appointment with us, please notify us 24 hours in advance. Failure to notify us will result in a charge for the missed visit.

I understand that the care provided by the Doctors at Roots Natural Medicine is on a cash, check or credit card basis that is due at time of service and that I will be provided with a receipt for services and payment, which I may send to my insurance company for appropriate reimbursement.

Patient's Signature:_____
(*or legal guardian if under 18 years old*)

Date:_____

**Children are 15 years old and under.*

CHIROPRACTIC FEE SCHEDULE

First Office Visit *(1 hour)*	**$130**
Regular Office Visit *(30 min)*	**$75**
Extended Office Visit *(45 min)*	**$100**
Regional Office Visit *(15 min)*	**$48**
***Child First Office Visit**	**$90**
***Child Regular Office Visit**	**$50**

NATUROPATHIC FEE SCHEDULE

First Office Visit *(1 hour)*	**$180**
Return Visits *(30 min)*	**$95**
***Child First Office Visit**	**$120**
***Child Return Visit**	**$60**