REGISTRATION & HISTORY

Date ____________________

Welcome to our office!

Please fill out this Confidential Client Intake Form as **thoroughly** as possible.

CLIENT INFORMATION

Client ____________________

Address ____________________

____

City State Zip

Primary Phone (Home/Work/Cell) ____________________

Secondary Phone (Home/Work/Cell) ____________________

Best time and number to reach you at ____________________

Sex: ☐ M ☐ F Age ___ Date of Birth ____________________

☐ Single ☐ Married ☐ Other

Client SS# ____________________

Email ____________________

Employer ____________________

Employer Address ____________________

____

City State Zip

Employer Phone ____________________ ext. ________

Occupation ____________________

Number of hours worked per week ____________________

How did you hear about us? ____________________

IN CASE OF EMERGENCY, CONTACT

Name ____________________

Relationship ____________________

Phone ____________________

PRIMARY CARE PHYSICIAN

Name ____________________

Address ____________________

____

Phone ____________________ Fax ____________________

Date Last Seen ____________________

ACCIDENT INFORMATION Complete if injury is due to an accident

Is client injury related to:

☐ employment ☐ auto accident State ________

☐ other accident ☐ crime (Only for Medicaid)

Attorney Name (if applicable) ____________________

Address ____________________

INSURANCE Complete if you want to submit for reimbursement

Who is the **Primary Card Holder**? ____________________

Relationship to client ____________________

Address (if different from client) ____________________

____

City State Zip

Phone number (if different from client) ____________________

Date of Birth of Primary Card Holder ____________________

ID Number ____________________ Group # ____________________

Insurance Co. ____________________

Is client covered by additional insurance? Yes No

Who is the **Secondary Card Holder**? ____________________

Relationship to client ____________________

Address (if different from client) ____________________

____

City State Zip

Phone number (if different from client) ____________________

Date of Birth of Secondary Card Holder ____________________

ID Number ____________________ Group # ____________________

Insurance Co. ____________________

Client is financially responsible for all charges whether or not reimbursed by insurance.

MEDICATIONS

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

VITAMINS / HERBS / SUPPLEMENTS

____________________ ____________________

____________________ ____________________

____________________ ____________________

ALLERGIES

____________________ ____________________

____________________ ____________________

Get Well Naturally . . . Live to Your Potential

398A Evans St Williamsville, NY 14221

716-632-2200

CLIENT CONDITION

Reason for visit ____________________

When did your symptoms appear? ____________________ How did this happen? ____________________

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown

How often do you have this pain? ____________________ Is it constant or does it come and go? ____________________

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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other

What treatment have you already received for your condition? ☐ Medical ☐ PT ☐ Chiropractic ☐ None ☐ Other ______

Name of other doctor(s) who have treated you for your condition ____________________

Suspected or known diagnosis of your condition ____________________

PAIN ASSESSMENT

Type of Pain

☐ Sharp

☐ Dull

☐ Throbbing

☐ Aching

☐ Shooting

☐ Cramps

☐ Stiffness

☐ Swelling

☐ Numbness

☐ Burning

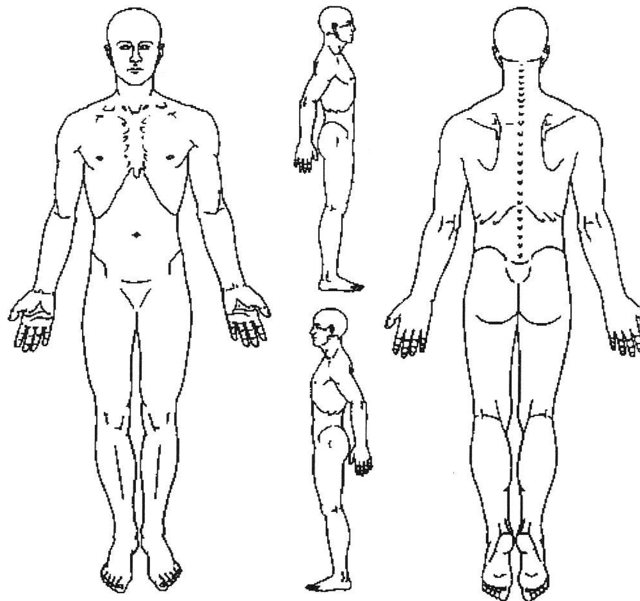
☐ Tingling

☐ Pressure

☐ Other ______

Pain Diagram

On the diagram below, please indicate where you are experiencing pain or other symptoms right now.



Pain Scale

Please rate the severity of your pain on a scale from 0 to 10

Worst pain imaginable
10
9
8
7
6
5
4
3
2
1
0
No pain

GOALS

What are your goals for coming here ____________________

____

PAST INJURIES / SURGERIES

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Joint Replacements		