FIRSTMOVE
Performance Health

PATIENT INTAKE FORM

Patient information contained within this form is considered strictly confidential. Your honest responses allow us to better understand your current and past health issues, and ensure the delivery of appropriate treatment.

NAME_____GUARDIAN_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE(CELL)_____HOME_____EMAIL_____

DOB_____SEX(M or F)_____MARITAL STATUS_____

SSN_____OCCUPATION_____

HOW DID YOU HEAR ABOUT US_____

IF REFERRED, MAY WE THANK THEM?(Y, N, N/A)_____

EMERGENCY CONTACT: NAME and RELATION_____PHONE_____

MEDICAL HISTORY

Below, check all boxes that apply. Place a “P” if you have had in the past. Place a “N” for now.

___Abdominal Pain
___Alcoholism
___Allergy
___Anemia
___Arthritis
___Asthma
___Cancer
___Chest Pain
___Cold/Infection
___Colon Trouble
___Constipation
___Depression
___Diabetes
___Dizziness
___Epilepsy
___Fatigue
___Gall Bladder
___Gout
___Gynecological Problem
___Hearing Issues
___Heart Disease
___Headaches
___Hemorrhoids
___Hepatitis
___High Blood Pressure
___HIV/AIDS
___Indigestion
___Kidney Trouble
___Liver Trouble
___Lung Problems
___Mental Disorders
___Nasuea
___Nervousness
___Pneumonia
___Poor Appetite
___Prostate Issues
___Sciatica
___Shortness of Breath
___Sinus Trouble
___Sleeplessness
___Stress
___Stroke
___Thyroid Trouble
___Ulcers
___Varicose Veins
___Vision Problems
___Weight Gain
___Weight Loss

PATIENT SIGNATURE_____ DATE_____

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Have you had any hospitalizations in the past 5 years (Y/N)? If yes, explain:

_____

Have you had any broken bones (Y/N)? If yes, explain:

_____

Have you had any past or recent surgeries (Y/N)? If yes, explain:

_____

Please list any current medications:

_____

Please list any allergies:

_____

FAMILY MEDICAL HISTORY

For the following family members, please list any past or present medical conditions (IE: Heart disease, Cancer, Diabetes, High Blood Pressure, ect.)

Mother:_____

Father:_____

Sister(s):_____

Brother(s):_____

Grandparent(s):_____

CHIEF COMPLAINT

Chief Complaint(s):_____

Date of Injury:_____ Date Symptoms Began:_____

Are your pain or symptoms(Circle One): Improving Worsening Not Changing

Are your pain or symptoms(Circle One): Constant Frequent Intermittent

Have you had a similar problem before? Yes or No. If Yes, when?_____

What makes your symptoms feel better?_____

What makes your symptoms feel worse?_____

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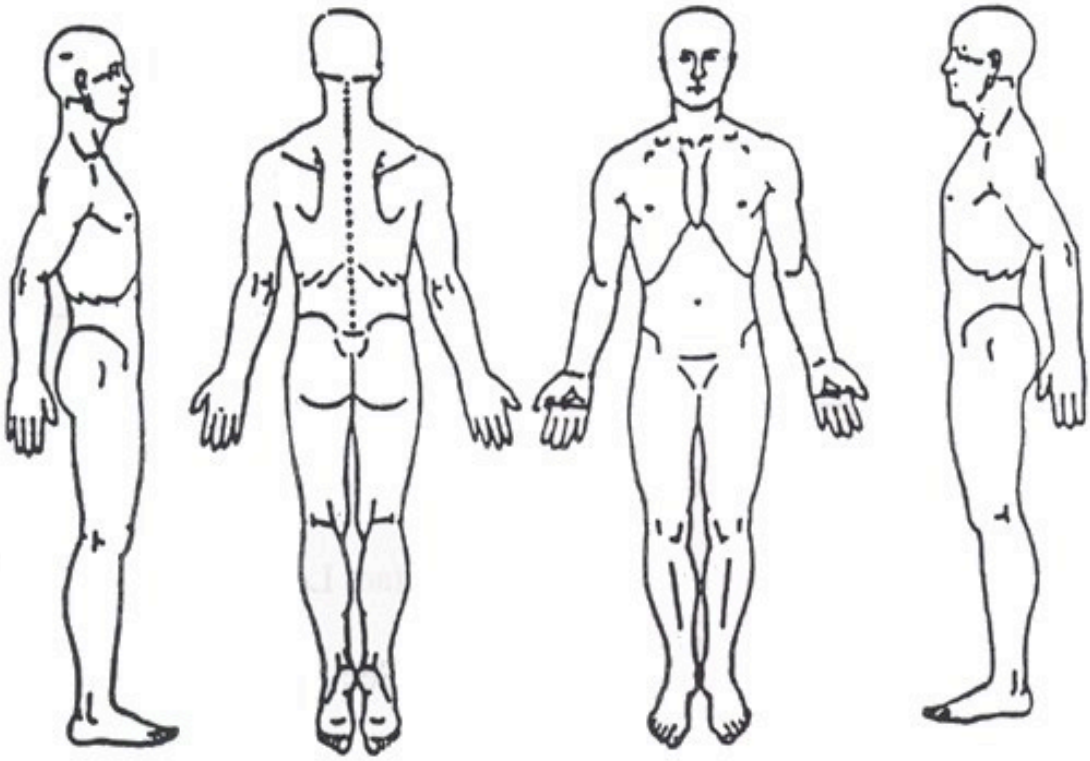
Please list each area of your symptoms in order of most severe to least severe. Then, using the scale below, mark an "**X**" on the scale that demonstrates the level of severity.

Areas of Symptoms	**Severity** (0 no pain, 10 severe pain)
1.) _____	0 1 2 3 4 5 6 7 8 9 10
2.) _____	0 1 2 3 4 5 6 7 8 9 10
3.) _____	0 1 2 3 4 5 6 7 8 9 10
4.) _____	0 1 2 3 4 5 6 7 8 9 10

On the Diagrams below, please indicate where you are experiencing symptoms by marking the diagram using the following abbreviations:

P=Pain **S**=Stiffness **B**=Burning **N**=Numbness **T**=Tingling



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