NEXT LEVEL
SPINE & SPORTS INJURY CENTER

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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:**_____
Insurance: _____
Address: _____
_____
Date of Birth:_____
Marital Status: ☐ single ☐ married
Home Phone: _____ **Cell:** _____
Email: _____
Occupation: _____**Employer:**_____

Mark (c) for current problems. Check and indicate the age when you were diagnosed.

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Autoimmune disease
☐ Bleeding disorders	☐ Cancer/Tumor	☐ Cardiovascular disease	☐ Chest pain
☐ COPD/Emphysema	☐ Depression	☐ Diabetes	☐ Difficulty breathing
☐ Dizziness	☐ Emotional/Mental disorders	☐ Epilepsy/Seizures	☐ Fatigue
☐ Fever	☐ Gallbladder disease	☐ Gastrointestinal disorders	☐ Gout
☐ Headache	☐ High blood pressure	☐ High cholesterol	☐ Irregular heart beat
☐ Kidney disorders	☐ Urinary disorders	☐ Unintentional weight loss/gain	☐ Loss of balance
☐ Loss of smell or taste	☐ Lung disorders	☐ Menstrual irregularities	☐ Migraines
☐ Numbness/tingling	☐ Osteoporosis	☐ Pacemaker	☐ Prostate disorders
☐ Previous surgery	☐ Pregnancy (___ weeks)	☐ Recent vision/hearing changes	☐ Shortness of breath
☐ Skin disorders	☐ Sleep disturbances	☐ Smoking	☐ Stroke (__/__/__)
☐ Swelling	☐Thyroid disorders	☐ Ulcers	☐ Weakness
☐ Other			

Family History: *For blood relatives and indicate which relative(s)*

☐ Arthritis
☐ Autoimmune conditions
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Stroke

Past Health History: *if yes, explain briefly below*

☐ Hospitalization in the last 5 years
☐ Broken bones
☐ Joint replacements
☐ Strains/Sprains
☐ Surgeries

_____
_____
_____

_____
_____
_____

Please list any medications or dietary supplements you are currently taking and why:

_____
_____
_____

Patient Intake Form (page 2)

Give a brief detailed description of what specific issue caused you to seek care:

_____

_____

_____

What seemed to be the initial cause? _____

How long have you had this condition? _____ Is it worsening? □ yes □ no

Does anything make the condition better (certain activity, other)? _____

Does anything worsen the condition (particular movements, other)? _____

Have you received prior treatment (physical therapist, medical doctor, other)? _____

If so, what was the treatment and what were your results? _____

_____

Have you had previous diagnostic testing? □ X-Ray □ CT □ MRI □ other _____

When/Where? _____

What is your goal for seeking care today? _____

_____

Mark the area(s) of complaint indicating what you have been experiencing: P= pain; T = tightness; N = numbness or tingling; W = weakness