

Boundary Wellness Center
Patient Intake Form
185 Merritts Road Farmingdale, N.Y.
(T) 516-694-1590 (F) 516-249-8213

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment. Please print out this form and bring the completed form to your first appointment.

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____ Sex: Male Female

Marital Status: Single Married Other

Spouse Data

First Name _____ Middle Initial ____ Last Name _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular	Cervical spine	Hysterectomy
Cranial/Brain	Shoulder	Thoracic spine	Urogenital
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Carpal Tunnel	Gastrointestinal	Knee	Hernia
Other _____			

Please give a brief description of the problem[s] you are experiencing:

When did the problem start? _____

Is/Are the problem[s] getting better? Yes No or getting worse? Yes No

What appears to be the initial cause? _____

What types of treatment(s) did you receive for your condition? (Circle all that apply)

Chiropractic Physiotherapy Acupuncture Massage Surgery Pharmaceuticals Epidural

Complaint Location: _____

Onset: Acute Chronic Gradual

Quality: Achy Dull Stiff Tight Sharp Throbbing

Range: How does it feel at its best? (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

How does it feel at its worst? (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

Place an X next to "yes" or "no" to indicate if you have had any of the following:

Aids/HIV	___yes___no	Glaucoma	___yes___no	Pinched Nerve	___yes___no
Alcoholism	___yes___no	Gonorrhoea	___yes___no	Pneumonia	___yes___no
Allergy shots	___yes___no	Goiter	___yes___no	Polio	___yes___no
Anemia	___yes___no	Gout	___yes___no	Prostate Problems	___yes___no
Anorexia	___yes___no	Heart Disease	___yes___no	Prosthesis	___yes___no
Appendicitis	___yes___no	Hepatitis	___yes___no	Psychiatric Care	___yes___no
Arthritis	___yes___no	Hernia	___yes___no	Rheumatoid Arthritis	___yes___no
Asthma	___yes___no	Herniated Disc	___yes___no	Rheumatic Fever	___yes___no
Bleeding Disorders	___yes___no	Herpes	___yes___no	Scarlet Fever	___yes___no
Breast Lump	___yes___no	High Cholesterol	___yes___no	STD's	___yes___no
Bronchitis	___yes___no	Kidney Disease	___yes___no	Stroke	___yes___no
Bulimia	___yes___no	Liver Disease	___yes___no	Suicide Attempt	___yes___no
Cancer	___yes___no	Measles	___yes___no	Thyroid Problems	___yes___no
Cataracts	___yes___no	Migraine	___yes___no	Tonsillitis	___yes___no
Chemical Dependency	___yes___no	Miscarriage	___yes___no	Tuberculosis	___yes___no
Chicken Pox	___yes___no	Mononucleosis	___yes___no	Tumors, Growths	___yes___no
Diabetes	___yes___no	Multiple Sclerosis	___yes___no	Typhoid Fever	___yes___no
Emphysema	___yes___no	Mumps	___yes___no	Ulcers	___yes___no
Epilepsy	___yes___no	Osteoporosis	___yes___no	Vaginal Infections	___yes___no
Fracture	___yes___no	Pacemaker	___yes___no	Whooping Cough	___yes___no
Hand Dominance	___R___L	Parkinson's	___yes___no	Other: _____	