REINFORCE HEALTH & WELLNESS

Patient Intake Form

Patient Information

Name: ____________________ **Date:** __________

Date of Birth: ____________ □ male □ female

Marital status (circle)

S M W D Sep

Social Security #: __________________________

Address: _________________________________

____

E-Mail: __________________________________

Phone #: home: __________ **work:** __________

Emergency Contact:

Name: _________________________________

Number: _______________________________

Occupation: ______________________________

Employer: _______________________________

Accident Information

Is the condition due to an accident? □ **Yes** □ **No**

If yes, please complete ***Personal Injury Form***

Insurance Information

Insurance Co.: ___________________________

Group #: ____________ **Policy #:** ___________

Primary Card Holder: ______________________

Birthdate of Insured: ______________________

Relationship to Patient: ___________________

Assignment and Release:

I certify that I, and/or my dependents, have insurance coverage with ________________ and assign directly to (Dr. David Kim / Dr. Lesley Wong) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use for my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

X:__________________________

Date:________________________

Patient Condition

Give a breif detailed description of the problem you are currently experiencing: ___________________

____

How long have you had this condition? _______________ **Is it getting worse?** □ **yes,** □ **no**

Rate the severity of your pain on a scale from 1 (least pain) to 10 (worst pain) ____________________

Type of pain: □ **Sharp** □ **Dull** □ **Throbbing** □ **Numbness** □ **Burning** □ **Aching**

□ **Shooting** □ **Tingling** □ **Cramping** □ **Stiffness** □ **Swelling** □ **Other**

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**

What treatment have you already received for your condition? _________________________________

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

____

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Health History

Mark (c) for current problems, check and indicate the age when you had any of the following:

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

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Hearing loss
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Abdominal bloating
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

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

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

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Exercise:
- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Heavy

Work Activity:
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

Other Habits:
- ☐ Smoking — Packs/Day ___________
- ☐ Alcohol — Drinks/Week __________
- ☐ Coffee/Caffeine — Cups/Day ____________
- ☐ Stress — Reason ______________

Are you pregnant? □ Yes □ No   If yes, due date ___________________________

Injuries/Surgeries- Please describe major injuries and any surgical procedures performed: _____________________________________

____

Date of last: Physical Exam _______________ Spinal Exam _______________

Spinal X-ray ______________ Blood/Urine test _______________

MRI/CT/Bone Scan ______________________

MEDICATIONS

(Include name, dosage, frequency, duration)

Prescription-

Over-the-counter-

ALLERGIES

Supplements

(Include name, dosage, frequency, duration, brand, route of administration)

Patient Goals/Expectations

What are your goals/expectations of your care-

( ) relief care - primary goal is to relieve your symptoms
( ) corrective care - complete the correction begun in the relief care
( ) stabilization - stabilize structures supporting the spine to prevent future episodes
( ) wellness - promotion of optimal functioning of all bodily systems
( ) other: ____