Jacksonville Integrative Health - Intake Forms

Date ____________________ Phone ____________________

First Name ____________________ Initial ______ Last Name ____________________

Street Address ____________________

City / State / Zip Code ____________________

Date of Birth ____________________ Age ________ Sex ☐ Male ☐ Female

Social Security # ____________________ Email ____________________

Pregnancy ☐ Yes ☐ No ☐ Not Sure ☐ N/A

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer ____________________ Occupation ____________________ Work Phone ____________________

Emergency Contact ____________________ Relationship ____________________ Phone ____________________

PRESENT COMPLAINTS (Mark all that apply)

☐ Headache ☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain ☐ Low Back Pain

☐ R ☐ L Shoulder Pain ☐ R ☐ L Hip Pain ☐ R ☐ L Knee Pain ☐ Chest Pain

☐ R ☐ L Ankle/Foot Pain ☐ R ☐ L Wrist Pain ☐ R ☐ L Elbow Pain

☐ R ☐ L Pain travels down leg ☐ R ☐ L Pain travels down arm

☐ R ☐ L Numbness / Tingling in Leg/Foot ☐ R ☐ L Numbness / Tingling in Arm/Hand

Other ____________________

Rate the severity of your overall pain with **0 equals no pain** and **10 equals worst pain**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Which of the above complaints is the worst?

____

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Currently taking MEDICATIONS? ☐ Yes ☐ No, If Yes, Please specify below

____

____

Do you have ALLERGIES? ☐ Yes ☐ No, If Yes, Please specify below

____

____

SOCIAL HISTORY **Do you Smoke?** ☐ Yes ☐ No

If Yes, ☐ Heavy Smoker ☐ Light Smoker If No, ☐ Former Smoker ☐ Never

Do you drink Alcohol? ☐ Yes ☐ No, If Yes, number of drinks per week? ____________

Do you Exercise? ☐ Yes ☐ No, If Yes, number of days per week? ____________

SURGICAL HISTORY **Any Surgeries?** ☐ Yes ☐ No, If Yes, Please specify below

____

____

FAMILY HISTORY (Mark all that apply)

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Back Problems ☐ Cancer

☐ Stroke ☐ Rheumatoid Arthritis ☐ High Cholesterol ☐ Thyroid Problems

☐ Osteoporosis ☐ Intestinal Problems ☐ Depression ☐ Alcohol/drug addiction

Other ____

Primary Care Physician? ☐ Yes ☐ No, If Yes, please provide name and phone

____

I give permission to Jacksonville Integrative Health to contact my primary care provider, in order to achieve greater results. These lines of communication will only benefit care and progress during the treatment plan. ☐ Yes ☐ No

I acknowledge and give permission to Jacksonville Integrative Health to communicate with me through text, email and/or phone calls. ☐ Yes ☐ No

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PERSONAL MEDICAL HISTORY (Mark all that apply)

☐ **No Medical Problems** (no prior history of any significant medical problems)

Bone & Joint Disorders

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Degenerative Disc Disease ☐ Sciatica

☐ Herniated/bulging Disc ☐ Ankylosis Spondylitis ☐ Osteoporosis ☐ Gout ☐ Lupus

☐ Spinal Stenosis ☐ Back Pain ☐ Neck Pain ☐ Hip Pain ☐ Shoulder Pain

Neurological Disorders

☐ Stroke or TIA ☐ Traumatic Brain Injury ☐ Parkinson's ☐ Cerebral Palsy

☐ Peripheral Neuropathy ☐ MS ☐ Migraines ☐ Headaches

Cardiac / Heart and Peripheral Vascular Disease

☐ Chest Pain / Angina ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack

☐ Arrhythmia ☐ Heart Murmur / Valve Disorder ☐ Deep Vein Thrombosis

☐ Bleeding Problems ☐ Peripheral Vascular Disease ☐ Congestive Heart Failure

Gastrointestinal Disorders

☐ Ulcer ☐ IBS ☐ Diverticulitis ☐ Acid Reflux / GERD ☐ Liver Disease

☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Hepatitis ☐ GI Bleed

Genitourinary Disorders

☐ Urinary Tract Infection ☐ Kidney Problems ☐ Dialysis ☐ Kidney Stones

☐ Bladder Problems ☐ Prostate Problems

Metabolic & Other Disorders

☐ Diabetes ☐ Thyroid Problems ☐ Skin Disorders ☐ Depression ☐ Anxiety

☐ Sickle Cell Anemia ☐ Anemia ☐ Psoriasis ☐ Venereal Disease ☐ Fatigue

Other ☐ Yes ☐ No　　**Cancer** ☐ Yes ☐ No

____________________ / ____________________

If Yes, Please Specify　　If Yes, Please Specify

____

Medical / Surgical Implants

________________　　____________________

Date　　Signature