

Candidate Qualification Form

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

1. First Name:

Last Name:

DOB:

Age:

Sex:

2. Home Address

Address 1

Address 2

City

State

Zip Code

3. Contact Information

Mobile Phone

Primary Email Address

Employer

Occupation

4. Demographic Information

Marital Status:

Single Married Divorced Widowed Other

5. Spouse's Name:

6. Who Helps You With Your Health Conditions? (family/important persons)

7. Emergency Contact Information

Emergency Contact Name:

Contact Phone Number:

Relationship to Patient:

8. How Did You Hear About Our Office?

- Facebook Advertisement
- Google Search
- Friend
- Physician
- Radio

Other:

9. Are you a participant with Medicare?

- Yes
- No

10. Are you a participant with Medicaid?

- Yes
- No

11. DO YOU HAVE A PACEMAKER?

- yes
- no

VISIT PURPOSE

12. What in the MAIN THING you want us to help you with?

13. Write your symptoms and where you experience them.

14. How long have you been suffering from these symptoms?

15. What treatments have you tried in the past for this condition?

16. What seems to make your condition worse? Circle all that apply.

- Sitting
- Standing
- Walking
- Sleeping
- Self-care/Showering
- Chores
- Hobbies
- Exercise
- Other

17. How is this interfering with your life? Circle all that apply.

- | | | |
|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Kids | <input type="checkbox"/> Future |
| <input type="checkbox"/> Ability | <input type="checkbox"/> Marriage | <input type="checkbox"/> Self Esteem |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Time | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Freedom | <input type="checkbox"/> Other | |

18. Where do you see yourself in 1 year if it continues to progress?

19. What WORRIES YOU THE MOST about this condition?

Health Conditions

20. CONSTITUTIONAL

- | | | |
|--|--------------------------------|---------------------------------|
| <input type="checkbox"/> rapid weight loss | <input type="checkbox"/> fever | <input type="checkbox"/> chills |
| <input type="checkbox"/> weakness | <input type="checkbox"/> N/A | |

21. SKIN

- | | | |
|-------------------------------|----------------------------------|------------------------------|
| <input type="checkbox"/> rash | <input type="checkbox"/> itching | <input type="checkbox"/> N/A |
|-------------------------------|----------------------------------|------------------------------|

22. HEENT/HEAD, EYES, EARS, NOSE OR THROAT

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> visual loss | <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision |
| <input type="checkbox"/> yellow eyes | <input type="checkbox"/> hearing loss | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> congestion | <input type="checkbox"/> runny nose | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> N/A | | |

23. CARDIOVASCULAR

- | | | |
|--|---|---|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chest pressure | <input type="checkbox"/> chest discomfort |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> edema | <input type="checkbox"/> N/A |

24. RESPIRATORY

- | | | |
|--|---|------------------------------|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> cough or mucus | <input type="checkbox"/> N/A |
|--|---|------------------------------|

25. GASTROINTESTINAL

- | | | |
|---|---|---|
| <input type="checkbox"/> anorexia | <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting or diarrhea |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> blood in stool | <input type="checkbox"/> N/A |

26. GENITOURINARY

- burning in urination
- pregnancy
- N/A
- other

27. AT ANY POINT HAVE YOU LOST COMPLETE CONTROL OF YOUR BOWEL OR BLADDER?

- Yes
- No

28. NEUROLOGICAL

- headache
- dizziness
- loss of consciousness
- paralysis or weakness
- difficulty walking
- numbness/tingling in the extremities
- N/A

29. HAVE YOU HAD ANY NUMBNESS AROUND YOUR GROIN OR ANUS?

- Yes
- No

30. MUSCULOSKELETAL

- muscle, back pain, joint pain or stiffness
- N/A

31. HEMATOLOGIC

- anemia
- bleeding or bruising
- N/A

32. LYMPHATICS

- enlarged nodes
- history of splenectomy
- N/A

33. PSYCHIATRIC

- history of depression or anxiety
- N/A

34. ENDOCRINOLOGIC

- excess sweating
- cold or heat intolerance
- frequent urination or thirst
- N/A

35. Do you have Diabetes?

- Yes
 - No
 - Pre-diabetic
- _____
- Type 1
 - Type 2
- _____

36. If Diabetic, what year were you diagnosed? What was your last A1C?

37. ALLERGIES, please specify

38. SEVERE ALLERGIES: Please specify any substances you are severely allergic to

39. List of MEDICATIONS taken: (include over the counter)

If other,specify:

40. PRE-EXISTING ILLNESSES

If other, specify:

41. PREVIOUS SURGERIES, TREATMENTS, & TESTS PERFORMED

If Yes, specify:

42. Do you have any HARDWARE in your spine?

Yes

No

43. Have you had any FRACTURES in your spine?

Yes

No

44. Date of you last MRI for the Spine: If you haven't had one, put N/A

45. Does anyone in your family have any of these disorders?

Heart Disease

Stroke

Circulatory Disorder

Hypertension

Diabetes

other

N/A

46. Do you smoke TOBACCO PRODUCTS?

Yes

No

47. Do you have a HISTORY OF DRUG ABUSE?

Yes

No

48. Do you drink ALCOHOL?

Yes

No

Occasionally

Socially

Often

Signature

Date