Center for Musculoskeletal Care

# New Patient Intake Form

PATIENT NAME: _____

WOMEN ONLY

Are you pregnant? _____Yes _____No  If Yes, how many months? _____  Date of last period: _____

Age Menopause _____  Number of Live Births _____  Pregnancies Lost _____

Hot Flashes _____  Pelvic Pain _____  Lumps in Breast _____  PMS Syndrome _____

PAP exam (date): _____  Mammogram (date): _____  Thermography (date): _____

LIFESTYLE (please describe your habits)

Alcohol Use  Yes _____ No _____  How much? _____

Caffeine Intake  Yes _____ No _____  How much? _____

Tobacco Use  Yes _____ No _____  How much? _____

Recreational drugs  Yes _____ No _____  How often? _____

Exercising  Yes _____ No _____  How often? _____

Soft Drinks  Yes _____ No _____  How much? _____

Water Intake  Yes _____ No _____  How much?_____

Healthy Diet  Yes _____ No _____  Not sure _____  Need Help _____

STRESS LEVEL: Please rate your stress level on a scale of 0 (no stress) to 10 (highly stressed)

0  1  2  3  4  5  6  7  8  9  10

HOW MUCH SLEEP DO YOU AVERAGE PER NIGHT? _____ hours

What is your preferred sleeping position? _____

What is the type and age of your mattress and pillow? _____

OTHER:
In addition to the main reason for your visit today, do you have any other health issues or concerns that we should be made aware of? _____

_____

PRIMARY CARE PHYSICIAN: _____ PHONE # _____

ADDRESS: _____

May we communicate with your primary physician or referring doctor?_____

_____ I HAVE REVIEWED AND CONFIRMED THE INFORMATION WITH THE PATIENT

PHYSICIAN SIGNATURE : _____  DATE :_____

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