

Patient Intake



Date: _____

First name	Last name	Email*
Preferred pronouns	Phone number	Birth Date
Address	City & State	Zip code
SSN:	Your occupation	Emergency contact name & phone number

*Your email will NOT be shared with any 3rd parties and is used for occasional office announcements and promotions

How did you hear about flourish?

Please **circle** all **past and present** conditions

- | | | | |
|-----------------------|----------------|----------------------|-------------|
| Abdominal / digestive | Anxiety | Arthritis/tendonitis | Dizziness |
| Depression | Diabetes | Fatigue | Headaches |
| High blood pressure | Sinus problems | Heart Conditions | Blood clots |

What brings you to our office today?

Date of onset:	Please describe when the pain / issues began
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History: Have you ever...?

If so, please describe and provide date (month / year)

Broken bones

Yes	No
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Been hospitalized

Yes	No
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Been in an auto accident

Yes	No
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Had surgery

Yes	No
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Turn page for more questions

Number of alcoholic drinks per week	Number of coffee cups per week	Number of times exercise per week
What are exercise types do you do?		Number of oz of water you drink a day
What day to day activities have you been having a hard time with?		
Anything else you would like your provider to know?		

The following questions are regarding your pain

On a scale from 0-10, with 10 being unbearable pain, how severe is your pain?

Pain Intensity	None			Mild			Moderate			Severe		
Pain level	0	1	2	3	4	5	6	7	8	9	10	

On the diagram below, use the letters to indicate type and location of discomfort:

D = Dull	SH = Sharp	A = Aching	C = Cutting	CR = Cramping
T = Throbbing	B = Burning	N = Numbing	TI = Tingling	CO = Constricting
SP = Spasm	ST = Stinging	S = Shooting	P = Pounding	

