

WALK IN or ACUTE INTAKE FORM

Patient's name: _____

Date: _____

Please list your chief complaint(s): _____

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	current	previous		current	previous		current	previous
<u>General Symptoms</u>			<u>Cardiovascular</u>			<u>Infections / Illnesses</u>		
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Numbness / tingling	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Plantar warts	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDs	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Artery hardening	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep/insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds / flus	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the ankles	<input type="checkbox"/>	<input type="checkbox"/>	<u>Muscles and Joints</u>		
Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>
			Angina	<input type="checkbox"/>	<input type="checkbox"/>	Backache	<input type="checkbox"/>	<input type="checkbox"/>
<u>Head / Neck</u>			Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>				Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>
Type _____			<u>Genitourinary</u>			Foot trouble L / R	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Trouble urinating	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
TMJ concerns	<input type="checkbox"/>	<input type="checkbox"/>	Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>	Elbow pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	Hip pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>				Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			<u>Gastrointestinal</u>			Weakness / loss strength	<input type="checkbox"/>	<input type="checkbox"/>
<u>Skin</u>			Poor digestion	<input type="checkbox"/>	<input type="checkbox"/>			
Rashes / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<u>Women's Health</u>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>
Boils / Hives	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>
Contagious skin disease	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache	<input type="checkbox"/>	<input type="checkbox"/>
			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>			Haemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Swollen breasts	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Liver concerns	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in the breast	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Bladder concerns	<input type="checkbox"/>	<input type="checkbox"/>	On birth control? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	# of pregnancies _____		
Asthma / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	# of children _____		
Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>						Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Do you consume alcohol or recreational drugs? If so, please list _____

Are you on any medications / supplements? If so, please list _____

 Have you ever had any accidents / fractures / falls / injuries / hospitalizations / surgeries? Yes No