Frackson Health Care
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CONFIDENTIAL PATIENT INTAKE FORM

Name _____ Preferred name & pronouns _____
Services Card (PHN) _____ Birth date (mm/dd/yyyy) _____/_____/_____
Address _____ City _____ Postal Code _____
Primary phone _____ Email address _____

Occupation _____ Employer _____
Emergency Contact _____ Relationship _____
Phone _____

What is your primary concern _____

When & how did this begin _____

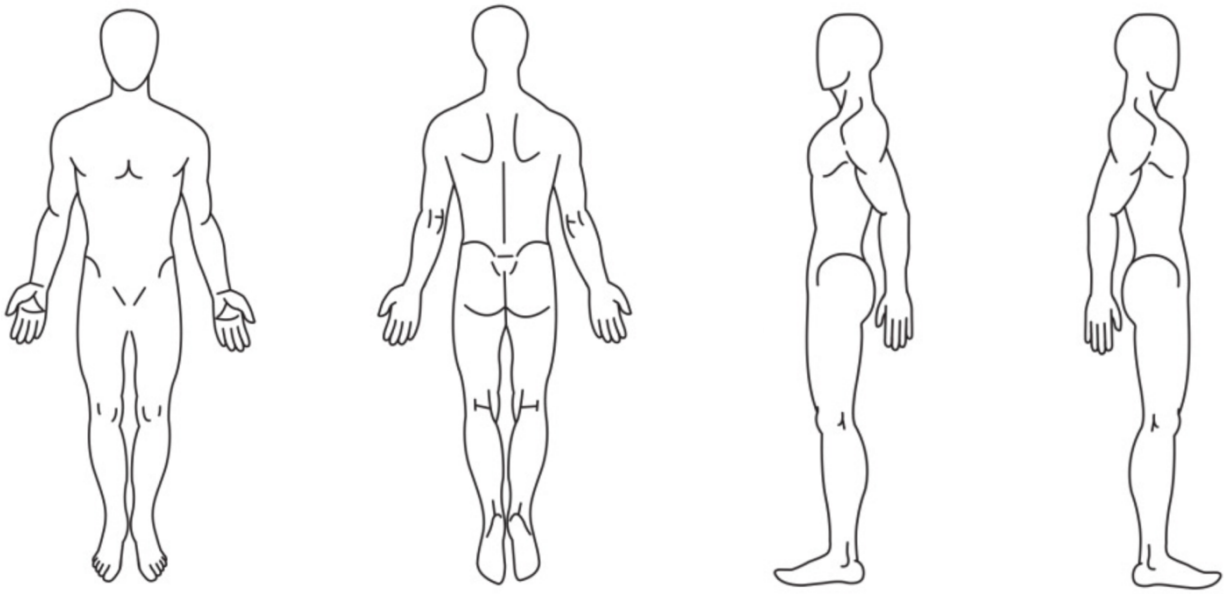
Did it occur: ☐Suddenly ☐Gradually Have you had this or similar conditions in the past: ☐Yes ☐No

If yes, please explain _____

What aggravates your condition _____

What relieves your condition _____

Please mark off the area(s) of your symptoms on the diagram below.



FRONT **BACK** **LEFT** **RIGHT**

Which of these describe your symptoms (select all that apply):
☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Shooting ☐Other _____

Please circle the number describing the intensity of your symptoms:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 *(Worst pain imaginable)*

Please fill out other side

Is your condition: ☐Constant ☐Intermittent Is your condition getting progressively worse? ☐Yes ☐No

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Other _____

Have you had previous treatment for the above symptoms? ☐Yes ☐No

If yes, please specify: When & what kind of treatment _____

How did you respond (e.g., helped, got worse, etc.) _____

Please list **ANY** surgeries & year _____

Please list **ALL** prescription drugs, over the counter drugs, vitamins and natural supplements you take:

_____

_____

Do you currently wear orthotics? ☐Yes ☐No

Are you affected by any of the following? Please place a checkmark in the box

S = Sometimes O = Often A = Always

	S	O	A		S	O	A		S	O	A
Headaches				Shortness of breath				Seasonal allergies			
Migraines				Disrupted sleep				Heartburn			
Dizziness				Constipation				Digestive upset			
Fatigue				Trouble urinating				Painful menstruation			
High blood pressure				Blood clots				PMS			
Are you currently pregnant? ☐Yes ☐No											

What do you hope to gain from your treatment here? Please check all that apply

☐Pain reduction ☐Return to function ☐Guidance for future prevention ☐Other _____

Please keep in mind that your treatment time is reserved specifically for you, A minimum of 24 hours' notice for rescheduling or cancelling appointments is required. There will be a charge of $65 for missed appointments or cancellations without 24 hours' notice.

Please initial in the box to indicate you have read and understood this policy ☐

Thank you for your patience and cooperation in completely filling out this form

Patient Signature _____ **Date** _____