

Primary Reason for Visit (Check all that apply)

☐ Neuro ☐ Decomp ☐ Contour ☐ Regen ☐ Incont

Patient Intake

Date: _____

1. PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone (Best #): _____ Email: _____
 Occupation: _____ Retired? ☐ Yes ☐ No
 Spouse / Significant Other (Name): _____ Phone: _____

How did you hear about us? (Check one)

☐ Referral ☐ FB/Instagram ☐ Google ☐ TV ☐ Newspaper ☐ Radio ☐ Seminar ☐ Other: _____

2. CURRENT HEALTH CONCERNS

What are your main health concerns? (Check up to 3)

☐ Numbness ☐ Electric Shocks
☐ Tingling ☐ Cold Hands/Feet
☐ Burning ☐ Swelling
☐ Sharp/Stabbing Pain ☐ Weakness/Heavy Feeling
☐ Aching ☐ Balance/Walking Problems
☐ Cramping ☐ Other: _____

Where are your symptoms? (Check all that apply)

☐ Feet / Toes ☐ Whole Body
☐ Legs ☐ One Side (Left / Right)
☐ Hands / Fingers ☐ Other: _____
☐ Low Back
☐ Neck

How long have you had these symptoms?

☐ < 3 months ☐ 3-6 months ☐ 6-12 months
☐ 1-2 years ☐ 2-5 years ☐ > 5 years

Have your symptoms been getting:

☐ Better ☐ Worse ☐ Staying the same
 Pain level in the last week (0-10): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
 No Pain Worst Pain Possible

What makes your symptoms worse?

What makes your symptoms better?

3. RELATED CONDITIONS / MEDICAL HISTORY (Check all that apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol
☐ Spinal Stenosis ☐ Herniated/Bulging Disc ☐ Sciatica
☐ Arthritis ☐ Poor Circulation/Vascular Disease ☐ Cancer / Chemotherapy
☐ Foot Surgery ☐ Pacemaker / Defibrillator ☐ Implanted Stimulator (e.g., Bladder)
☐ Poor Wound Healing ☐ Incontinence/ED
☐ Other: _____

Date: _____

4. TREATMENTS & MEDICATIONS

☐ What treatments have you already tried for your condition? (Check all that apply)

- | | |
|---|---|
| ☐ Chiropractic Care | ☐ Supplements / Vitamins |
| ☐ Physical Therapy | ☐ Bracing / Supports |
| ☐ Massage Therapy | ☐ Home Exercises |
| ☐ Acupuncture | ☐ Stem Cell / Regenerative Therapy |
| ☐ Injections (e.g., Cortisone) | ☐ Shockwave Therapy |
| ☐ Surgery | ☐ Laser Therapy |
| ☐ Prescription Medications | ☐ Spinal Decompression |
| ☐ Over the Counter Medications | ☐ Other: _____ |

☐ How effective were these treatments? (Check one)

- ☐ No improvement
☐ Slight improvement
☐ Moderate improvement
☐ Significant improvement
☐ Temporary relief only
☐ Made it worse
☐ Still trying
☐ Other: _____

5. MEDICATIONS, ALLERGIES & SUPPLEMENTS

List all prescription medications you are currently taking (or attach a list):

Medication Name	Dose (mg)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all allergies / sensitivities (medication, food, etc.):

Item you react to:	Reaction:
_____	_____
_____	_____

List all nutritional supplements (vitamins, herbs, etc.):

Supplement Name	Dose	Times Daily
_____	_____	_____
_____	_____	_____

6. LIFESTYLE & HABITS

- Do you smoke? ☐ Yes ☐ No ☐ Former If yes or former, how much per day? _____
 Do you drink alcohol? ☐ Yes ☐ No If yes, how many per week? _____
 Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _____
 How would you describe your diet? ☐ Healthy ☐ Average ☐ Poor
 How would you describe your stress level? ☐ Low ☐ Moderate ☐ High
 How many hours of sleep do you get per night? ☐ < 5 ☐ 5-6 ☐ 7-8 ☐ > 8

7. HOW THIS AFFECTS YOUR LIFE (Check all that apply)

- | | | |
|---|---|--|
| ☐ Work | ☐ Sleeping | ☐ Balance / Fear of Falling |
| ☐ Daily Activities | ☐ Mood / Stress | ☐ Ability to Perform Job Duties |
| ☐ Walking | ☐ Relationships | ☐ Quality of Life |
| ☐ Standing | ☐ Social Activities | ☐ Can't Do Things I Used to Enjoy |
| ☐ Sitting | ☐ Travel | ☐ Financial Impact |
| ☐ Exercise / Fitness | ☐ Household Activities | ☐ Other: _____ |
| ☐ Hobbies | ☐ Independence | |

Please describe how your condition affects your daily life:

8. QUALITY OF LIFE & GOALS

1. What are the 3 most important things you want to be able to do or improve?

1. _____
2. _____
3. _____

2. What are your biggest concerns about your condition getting worse in the future?

3. If nothing changes over the next 1–3 years, how do you think your life will be affected?

4. What would a successful outcome from care mean to you?

5. What are your treatment goals? (Check all that apply)

- | | | |
|--|--|---|
| ☐ Reduce Pain | ☐ Return to Work | ☐ Avoid Surgery |
| ☐ Improve Mobility | ☐ Return to Sports / Activities | ☐ Reduce / Eliminate Medications |
| ☐ Increase Strength | ☐ Be More Independent | ☐ Maintain Current Function |
| ☐ Improve Balance | ☐ Improve Quality of Life | ☐ Other: _____ |

9. ADDITIONAL INFORMATION

Is there anything else you would like us to know about your health, condition or goals?

Please list any additional health conditions, surgeries, or relevant information not already mentioned:

10. COMMUNICATION PREFERENCES

How would you like us to contact you? (Check all that apply)

- | | |
|---------------------------------------|--------------------------------|
| ☐ Phone Call | ☐ Email |
| ☐ Text Message | ☐ Mail |

Is it okay to leave a detailed message?

- ☐ Yes ☐ No

Preferred contact method: _____

11. PATIENT SIGNATURE

I certify that the information provided on this form is true and accurate to the best of my knowledge. I understand that this information will be used to assist in my care and treatment at Pivotal Health and Wellness.

Signature: _____ Date: _____