WILMINGTON CLINIC PATIENT INTAKE INFORMATION

WELCOME TO OUR OFFICE
Please fill out this confidential questionnaire as thoroughly as you can. This will stay in our records and will help us better understand your overall health.
THANK YOU!

Personal Information

Name:____ Date:_____________

Date of Birth:______ / ______ / ______ Age:______ Sex: Male / Female / Other

Address:_________________________________ City:________________ State:_____ Zip:________

Primary Phone:________-_______-_________ Cell Phone:________-_______-_________

Email: ______________________________________ Occupation:____________________________

Insurance provider: _____________________________

Would you like to receive **text** reminders of your appointments? ☐Yes ☐No

Would you like to receive **email** reminders of your appointments? ☐Yes ☐No

Is your visit today due to an: ☐ Auto Accident ☐ Work Injury ☐ Other

Date of occurrence:___________________

How did you hear about our clinic?____

Health Information

Height: ____ ft. ____ in. Weight:_____

Are you a smoker? ☐Yes ☐No If yes, how often? ☐Daily ☐Occasionally ☐Rarely

Are you a drinker? ☐Yes ☐No If yes, how often? ☐Daily ☐Occasionally ☐Rarely

If **female** are you pregnant? ☐Yes ☐No

Individual Health History: During this portion please select all that apply to you. Please explain if any family members suffer from these on the lines provided below.

☐Heart Disease ☐Psychiatric ☐Arthritis
☐High Blood Pressure ☐Diabetes ☐Cancer
☐Thyroid ☐Stroke ☐Cholesterol

____

____

Emergency contact

Contact 1: __________________________________ Relation:__________________

Phone: ___________________________

☐ By checking this box you are allowing the disclosure of information of your treatment records, as well as, allowing the Wilmington clinic and staff to reach out to the name listed above.

Agreements, Authorizations, and HIPAA Privacy Notice Consent

☐ By checking this box and signing below you are agreeing to the statements listed on the **AGREEMENTS, AUTHORIZATION, AND HIPAA PRIVACY NOTICE.**

PRINTED Name of Patient or Parent/Guardian:__________________________________

SIGNATURE of Patient or Parent/Guardian:____________________________________

Date:_______________________ Relation to patient:__________________________

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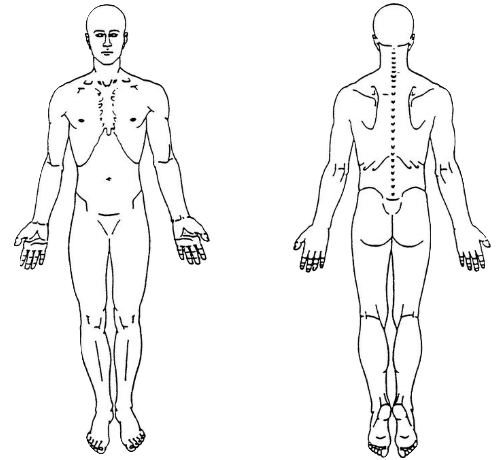
Area(s) of Complaint

Please indicate on the diagram where you have pain and/or symptoms



Primary Complaint:

Pain Level

Minimal → Severe

1) ____________________ 1 2 3 4 5 6 7 8 9 10

Additional Complaints:

2) ____________________ 1 2 3 4 5 6 7 8 9 10

3) ____________________ 1 2 3 4 5 6 7 8 9 10

4) ____________________ 1 2 3 4 5 6 7 8 9 10

5) ____________________ 1 2 3 4 5 6 7 8 9 10

Nature of Primary Complaint Pain:

☐ Sharp ☐ Stabbing ☐ Dull ☐ Achy ☐ Burning ☐ Shooting ☐ Tingling

Frequency of Primary Complaint Pain:

☐ Constantly (76-100% of the day)
☐ Frequently (51-75%of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

How are your symptoms changing:

☐ Getting Better
☐ Not Changing
☐ Getting Worse

Have you experienced this Primary Complaint before? ☐ Yes ☐ No

How did your symptoms start?________________________________

When did your symptoms start?________________________________

Other symptoms not listed above?________________________________

Is there anything that **alleviates** your pain?________________________________

Is there anything that **aggravates** your pain?________________________________

Is there any radiating pain? ☐ Yes ☐ No

If yes, please explain:________________________________

Have you seen any other health care professional for the primary complaint? ☐ Yes ☐ No

If yes, who have you seen?________________________________

What treatments did you receive?________________________________

Please explain any imaging/tests you have received for this complaint:________________________________

____

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Daily Routine Other:________________

Please explain:________________________________

What is your dominate hand? **Circle one:** RIGHT LEFT BOTH

How would you describe your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Is there anything else you would like to discuss with your doctor today?________________________________

____

____

Patient/Guardian Signature:________________________ Date:____________