CASTELLINI CARE red bank
acupuncture chiropractic physical therapy active release

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PATIENT INTAKE FORM

Please complete this questionnaire. This confidential history will be part of your records.

Name: ____________________ Birthday: __________ Sex: ❑ M ❑ F

Address: ____________________ City: __________ State: __________ Zip: __________

Soc. Sec. # ____________________ Email: ____________________

Home Phone: ____________________ Work Phone: __________ Cell Phone: __________

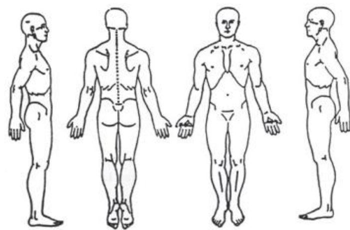
Marital Status: ❑ S ❑ M ❑ D ❑ w/children, ages: __________ Spouse's Name: __________

Insured's Name: ____________________ Insured's SSN: __________ Insured's DOB: __________

Your Occupation: ____________________ Employer: __________

Who referred you to us? ____________________ How else did you hear about us? __________

Indicate with an X on the drawings below where you have pain/symptoms.



List/describe the symptoms in order of severity

1 ____________________
2 ____________________
3 ____________________
4 ____________________
5 ____________________

How often do you experience your symptoms?

❑Constantly (76-100% of the time) ❑Occasionally (26-50% of the time)
❑Frequently (51-75% of the time) ❑Intermittently (1-25% of the time)

How would you describe your pain?

❑Sharp ❑Tingly ❑Numb ❑Sharp with motion ❑Diffuse ❑Shooting
❑Stiff ❑Dull ❑Achy ❑Shooting with motion ❑Burning ❑Stabbing with motion

Using scale from 0-10 (10 being the worst), how would you rate your condition? *(Please circle)*

0 1 2 3 4 5 6 7 8 9 10

How long have you had this condition? ____________________

Have you had this or similar conditions in the past? ____________________

Do any positions make it feel better? ____________________

Is this conditon: ❑ Improved ❑ Unchanged ❑ Getting worse

Is this condition interfering with activities of daily living? ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other: __________

Have other doctors or therapists treated this condition? ____________________

Please list surgical operations and years: ____________________

What is your: Height__________ Weight__________

Family Physician Name: ____________________ Phone Number: __________

List of Medications:

Name: __________ Dosage: __________ Frequency: __________
Name: __________ Dosage: __________ Frequency: __________

Patient's Name: ______________________

Medications Continued.

Name: ______________ Dosage: ______________ Frequency: ______________

Name: ______________ Dosage: ______________ Frequency: ______________

Have you been in an auto accident or had any other personal injury? ❑ Y ❑ N

If yes, please describe: ______________________

Indicate if you have any immediate family members with any of the following:

❑Rheaumatoid Arthritis	❑Diabetes	❑Lupus
❑Heart Problems	❑Cancer	❑ALS

Please mark any conditions that apply:

❑AIDS/HIV	❑Diabetes	❑Liver Disease	❑Rheumatoid Arthritis
❑Alcoholism	❑Emphysema	❑Measels	❑Rheumatic Fever
❑Allergy Shots	❑Epilepsy	❑Migraine	❑Scarlet Fever
❑Anemia	❑Fractures	❑Headaches	❑Sexually Transm. Disease
❑Anorexia	❑Glaucoma	❑Miscarriage	❑Stroke
❑Appendicitis	❑Goiter	❑Monomucleosis	❑Suicide Attempt
❑Arthritis	❑Gonorrhea	❑Multiple Sclerosis	❑Thyroid Problems
❑Asthma	❑Gout	❑Mumps	❑Tonsillitis
❑Bleeding Disorders	❑Heart Disease	❑Osteoporosis	❑Tuberculosis
❑Breast Lump	❑Hepatitis	❑Pacemaker	❑Tumors, Growths
❑Bronchitis	❑Hernia	❑Parkinson's Disease	❑Typhoid Fever
❑Bulimia	❑Herniated Disk	❑Pinched Nerve	❑Ulcers
❑Cancer	❑Herpes	❑Pneumonia	❑Vaginal Infections
❑Cataracts	❑High Blood Pressure	❑Polio	❑Whooping Cough
❑Chemical Dependency	❑High Cholesterol	❑Prosthesis	❑Other______________
❑Chicken Pox	❑Kidney Disease	❑Psychatric Care	______________________

What habits do you currently do?

❑Smoking Packs/Day______________ ❑Alcohol Drinks/Week____________ ❑Coffee Cups/Day_____________

What activities do you do at work?

❑Sit:	❑Most of the day	❑Half of the day	❑A little of the day
❑Stand:	❑Most of the day	❑Half of the day	❑A little of the day
❑Computer Work:	❑Most of the day	❑Half of the day	❑A little of the day
❑On the phone:	❑Most of the day	❑Half of the day	❑A little of the day

Print Patient Name: ______________________ Date: ______________

Patient Signature: ______________________ Date: ______________

Parent/Guardian Signature: ______________________ Date: ______________