TriMotus

PATIENT INTAKE

NAME ________________________________ BIRTHDATE:________________________

ADDRESS________________________________ CITY ____________________ STATE _______ ZIP __________

PHONE __________________________ WOULD YOU LIKE TO RECEIVE TEXT APPOINTMENT REMINDERS?** ☐ Yes ☐ No

CELL PHONE PROVIDER(for reminders) ______________________ EMAIL* ________________________________

EMERGENCY CONTACT ____________________________ EMERGENCY CONTACT PHONE ________________________

GUARDIAN(if applicable) ________________________ WHO MAY WE THANK FOR REFERRING YOU? __________________

What is your main concern?____

When did these symptoms start? ____

Did it come on: ☐ suddenly ☐ gradually

Please check any symptoms you are currently experiencing:

GENERAL: ☐ Changes in weight ☐ Fatigue ☐ Fever ☐ Chills ☐ Difficultly sleeping ☐ Anxiety ☐ Depression

EYES: ☐ Blurred Vision ☐ Floaters ☐ Eye pain ☐ Discharge

EARS: ☐ Ringing in ears ☐ Ear pain ☐ Swelling ☐ Loss or changes in hearing ☐ Discharge

PULMONARY: ☐ Shortness of breathe ☐ Chronic Cough ☐ Wheezing ☐ Snoring

CARDIOVASCULAR: ☐ Chest Pain ☐ Palpitations ☐ Syncope (Fainting) ☐ Lower leg swelling

GASTROINTESTINAL: ☐ Abdominal pain ☐ Difficulty swallowing ☐ Vomiting ☐ Nausea ☐ Heart burn ☐ Constipation ☐ Diarrhea ☐ Blood in stool

GENITO-URINARY: ☐ Urinary frequency ☐ Urgency ☐ Pain ☐ Blood in urine ☐ Discharge

NEUROLOGICAL: ☐ Dizziness ☐ Numbness ☐ Weakness ☐ Balance problems ☐ Headaches ☐ Migraines

MUSCULOSKELETAL: ☐ Back pain ☐ Muscle pain ☐ Joint pain

OTHER (Please explain)____

Patient / Guardian Signature:____ Date:______________

PATIENT INTAKE (cont)

Past Health History

Do you have any medical diagnosis? ☐ Yes ☐ No

If yes, Please explain: ______________________________

Have you had any serious injuries? ☐ Yes ☐ No

If yes, Please explain: ______________________________

Have you ever been a patient in the hospital? ☐ Yes ☐ No

If yes, Please explain: ______________________________

Have you had any surgeries? ☐ Yes ☐ No

If yes, Please explain: ______________________________

Do you have any allergies (Medicine or food) that you know of? ☐ Yes ☐ No

If yes, Please explain: ______________________________

Are you currently taking any Prescription, Over The Counter Medications or Herbal Supplements? ☐ Yes ☐ No

If yes, Please explain and state dosage :______________________________

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Family Health History

Do any of your parents, grandparents, siblings or your children, have or have they every had:

☐ Heart disease	☐ Arthritis	☐ Food allergies / sensitivity
☐ Stroke	☐ Cancer	☐ Diabetes
☐ High blood pressure	☐ Tuberculosis	☐ Blood disorders

☐ Other (please explain)______________________________

Personal / Social History

What type of work do you do? ______________________________

How much exercise do you get? (hours/week) ______________________________

What is your diet like? ______________________________

How many hours of sleep do you usually get at night?______________________________

How often do you have a bowel movement? ______________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week: ______________________________

Do you smoke? ☐ Yes ☐ No If yes, how many packs per week: ______________________________

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day: ______________________________

How much stress do you have in your life? ______________________________

Do you have any hobbies? ______________________________

Patient / Guardian Signature:______________________________ Date:________________

*By giving us your email address, you acknowledge your email will be used for communication purposes, including informing you of upcoming events and specials. You have the option to opt out of these communications at any time. We respect your privacy and we promise never to share, trade, sell, deliver, reveal, publicize, or market your email address in any way, shape, or form.

**By opting in to text appointment reminders, you agree to receive texts from a 3rd party on behalf of this office approximately 24 hours in advance of your scheduled appointment time. You further acknowledge that missed text reminders, regardless of who is at fault, do not negate the patient cancellation/missed appointment policy. Text reminders are an automated convenience option and it is ultimately your responsibility to be aware of and keep your scheduled appointments.

Authorization and Release

I certify that I am the patient or legal guardian listed above and I have the legal authority to authorize the examination and treatment of the above patient. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize and consent to physical examination and receipt of healthcare services including, but not limited to, diagnostic procedures and medical treatment necessary to my care, health coaching and wellness screening services as the doctors see fit. I understand this authorization applies and extends to subsequent visits and shall be valid until rescinded in writing or replaced by one of a later date. By agreeing to receive treatment, I acknowledge that my/my child's medical care, services and treatment will be provided by physicians as well as other assisting healthcare professionals (such as, Chiropractic Assistants, Residents, Interns, Personal Trainers or other Providers as designated by the treating physician). I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment regardless of possible insurance reimbursement status

Patient / Guardian Signature:____ Date:________________