



Intake Form

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

How did you find us? Patient (who): _____ Doctor (who): _____ Staff (who): _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Date of Birth: ____ / ____ / ____ Gender (circle one): Male Female Marital Status (circle one): M D W S

Employer: _____ Work #: _____ Ext: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Physician (PCP): _____ Phone # (PCP): _____

Reason for today's visit: _____

| | | | | |
|---|---|---|---|---|
| Urination difficulty or dribbling | 0 | 1 | 2 | 3 |
| Frequent urination | 0 | 1 | 2 | 3 |
| Feeling of incomplete bowel evacuation | 0 | 1 | 2 | 3 |
| Leg nervousness at night | 0 | 1 | 2 | 3 |
| Decrease in libido | 0 | 1 | 2 | 3 |
| Decrease in fullness of erections | 0 | 1 | 2 | 3 |
| Spells of mental fatigue | 0 | 1 | 2 | 3 |
| Increase in fat distribution - chest and hips | 0 | 1 | 2 | 3 |

- Mostly 2's and 3's: You need to stop, make a course correction and take action in that area
- Mostly 1's and 2's: You need to use caution, pay attention and start making changes in that area
- Mostly 0's and 1's: You're doing good in that area, keep moving

Think of it as if you are driving across country with a GPS. The more often you stop, pull off the road or take a detour (red), the more the GPS has to reroute itself. When the GPS is having to constantly recalculate and reroute, more energy is used, and your journey can become complicated. You need to make a course correction and take action to stay on the clearest route to wellness.



| Current Symptoms | | | |
|--|---|---|---|
| <p>1</p> <input type="checkbox"/> Knee Pain <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Tingling in Legs <input type="checkbox"/> Weakness In Legs ----- <input type="checkbox"/> Urinating Issues <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Ringing in Ears ----- <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Belching <input type="checkbox"/> Constipation | <p>3</p> <input type="checkbox"/> Indigestion <input type="checkbox"/> Vomiting ----- <input type="checkbox"/> Arm Pain <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Hands Cold <input type="checkbox"/> Mid-Back Pain <input type="checkbox"/> Numbness in Fingers <input type="checkbox"/> Shortness of Breath ----- <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Tingling in Arms | <p>5</p> <input type="checkbox"/> Back Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Hair Loss <input type="checkbox"/> Hay fever <input type="checkbox"/> Hives <input type="checkbox"/> Loss of Balance/Dizzy <input type="checkbox"/> Neck Pain/Stiffness <input type="checkbox"/> Nervousness ----- <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Diarrhea <input type="checkbox"/> Feet Cold <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Hemorrhoids | <p>6</p> <input type="checkbox"/> Loss of Smell/Taste <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Sight Sensitivity <input type="checkbox"/> Sinus Problems ----- <input type="checkbox"/> Cold/Hot Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Joints Swelling/Pain <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Stress <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ |
| <p>2</p> | <p>4</p> | <p>6</p> | <p>7</p> |

| Rate Your Activities | | | |
|--|--------------------------|--------------------------|--------------------------|
| <i>Rate the degree of pain related to performing these activities.</i> | | | |
| | None | Some | Always |
| Climbing Stairs..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Computer work..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving/riding in cars..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting in/out of cars..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting out of bed..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Using the restroom..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housework..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Running..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual Intercourse..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking care of child..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yard work..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



Are you currently taking any medications or supplements? *(Please include regularly used over the counter medications)*.....

| Medication Name | Dosage and Frequency |
|-----------------|----------------------|
| | |
| | |
| | |
| | |
| | |

| Supplement Name | Dosage and Frequency |
|-----------------|----------------------|
| | |
| | |
| | |
| | |
| | |

Do you have any medication, food, or environment allergies?

| Medication, Food or Location | Reaction |
|------------------------------|----------|
| | |
| | |
| | |
| | |
| | |
| | |

Please list 3 major health goals in order of priority:



Privacy Policies

We are committed to preserving the privacy of your medical information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of Your Wellness Connection (YWC).

***Treatment** includes activities performed by a practitioner, chiropractic assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you nonconfidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This Notice is posted in our lobby. We may revise our Notice from time to time. The effective date at the lower left-hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.



Financial Authorizations

All payments are expected prior to rendered services unless arrangement has been made in advance with OBMen. Our policy is that the patient or patient representative is responsible for all charges regardless of whether or not this office accepts insurance assignments. By providing a credit card on file with our office, you authorize OBMen to charge your credit or debit card for the full amount owed for services, supplements, and or supplies.

Consent for Payment and understanding of OBMen's privacy policies stated above:

Patient Signature: _____ Date: _____

Printed Name: _____

Others covered by this agreement: _____