WELCOME

CONFIDENTIAL PATIENT INTAKE **Today's Date: _____**

Name: _____
First Middle Last Maiden (if applicable)

Address: _____
Street City State Zip Code

Social Security # _____ Age: _____ Date of Birth: ___/___/___

Marital Status: M S W D (circle one) Spouses Name: _____

Children: _____ Your e-mail: _____
Names and ages

Occupation: _____ Employer: _____

Home Phone #: (___) _____ Work Phone #: (___) _____

Cell Phone #: (___) _____

Name of Emergency Contact: _____

Phone #: (___) _____ Relationship to Patient: _____

The undersigned patient specifically acknowledges full payment for all services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Dated: _____ _____
Patient's Signature

MOTOR VEHICLE or WORKER'S COMPENSATION ACCIDENT ONLY

Date of Accident or Injury: _____
Car accident/ Work/ Other

Insurance Company: _____

Address of Company: _____
Street City State Zip Code

Adjuster: _____ Phone #: (___) _____

Claim Number: _____ Policy Number: _____

RH
HEALTH & INJURY

5300 South Robert Trail, Suite 700, Inver Grove Heights, MN 55077 (651) 756-7941

RH
HEALTH & INJURY

NAME: _____ TODAY'S DATE: _____

List Your Pains/Complaints from Most Severe (Problem #1) to Least	Location of Problem #1	Location of Problem #2	Location of Problem #3	Location of Problem #4
	_____ _____	_____ _____	_____ _____	_____ _____
Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting, or Other (explain)?	❑ Sharp ❑ Dull ❑ Achy ❑ Throbbing ❑ Numb ❑ Tingle ❑ Electric/Shooting	❑ Sharp ❑ Dull ❑ Achy ❑ Throbbing ❑ Numb ❑ Tingle ❑ Electric/Shooting	❑ Sharp ❑ Dull ❑ Achy ❑ Throbbing ❑ Numb ❑ Tingle ❑ Electric/Shooting	❑ Sharp ❑ Dull ❑ Achy ❑ Throbbing ❑ Numb ❑ Tingle ❑ Electric/Shooting
How long have you had this?	_____ _____	_____ _____	_____ _____	_____ _____
Since it began is it getting:	❑ Better ❑ Same ❑ Worse	❑ Better ❑ Same ❑ Worse	❑ Better ❑ Same ❑ Worse	❑ Better ❑ Same ❑ Worse
What makes it better?	_____ _____	_____ _____	_____ _____	_____ _____
What makes it worse?	_____ _____	_____ _____	_____ _____	_____ _____
On a scale of 0-10 rate your discomfort:	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort
Frequency of Your discomfort	❑ Constant 75-100% ❑ Frequent 51-75% ❑ Occasional 25-50% ❑ 25% or less	❑ Constant 75-100% ❑ Frequent 51-75% ❑ Occasional 25-50% ❑ 25% or less	❑ Constant 75-100% ❑ Frequent 51-75% ❑ Occasional 25-50% ❑ 25% or less	❑ Constant 75-100% ❑ Frequent 51-75% ❑ Occasional 25-50% ❑ 25% or less
How have you taken care of this? Has it worked?	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
This issue is affecting my:	❑ Job or Childcare ❑ Marriage/Sex ❑ Sports/Hobbies ❑ Bowel/Bladder ❑ Digestion	❑ Job or Childcare ❑ Marriage/Sex ❑ Sports/Hobbies ❑ Bowel/Bladder ❑ Digestion	❑ Job or Childcare ❑ Marriage/Sex ❑ Sports/Hobbies ❑ Bowel/Bladder ❑ Digestion	❑ Job or Childcare ❑ Marriage/Sex ❑ Sports/Hobbies ❑ Bowel/Bladder ❑ Digestion
Helping this issue would increase my quality of life by:	❑ 10-30% ❑ 40-75% ❑ 80-100%	❑ 10-30% ❑ 40-75% ❑ 80-100%	❑ 10-30% ❑ 40-75% ❑ 80-100%	❑ 10-30% ❑ 40-75% ❑ 80-100%

People see us for different reasons. Some come for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes.

❑ Relief ❑ Correction of the Cause ❑ Prevention ❑ Let the doctor choose for me

NAME: _____ TODAY'S DATE: _____

Are you currently taking any prescription medication?

Yes **No** If yes, what for conditions?_____

Names of medication(s): _____

_____

Are you currently taking any non-prescription medication (aspirin, ibuprofen, Advil, Tums, Zantac, etc.)?

Yes **No** If yes, what types: _____

_____

Are you taking any nutritional supplements or herbs?

Yes **No** If yes, what types: _____

_____

Do you do any of the following?

- ❑ Smoke? How much?_____
- ❑ Use Alcohol? How much/often?_____
- ❑ Drink coffee/tea/soda pop How much?_____

Medical History

Please list any past hospitalizations, surgeries, broken bones, accidents/falls, and the date involved.

_____

_____

Please check any of the following symptoms you frequently have

❑ Frequent/Severe headaches	❑ History of heart attack/stroke	❑ High blood pressure
❑ Stomach issues/ulcer/reflux	❑ Poor concentration	❑ Diabetes
❑ Sleepy after meals	❑ Liver issues	❑ Gallstones
❑ Anemia	❑ Intestinal issues	❑ Diarrhea
❑ Constipation	❑ Balance problems/vertigo	❑ Ringing of the ear
❑ Male or female disorders	❑ under/over productive thyroid	❑ Foggy brain

Who is your Family Doctor/Primary Care Physician?_____

What is the name of their facility and their location? _____

_____

Over 70% of our patients allow us to examine their family members for free within the first 2 weeks of starting care. This is a 100% no obligation complimentary service. Would you like to take advantage of this?

❑ Yes ❑ No Thank You

Please list any other health concerns that you feel were not adequately addressed in these forms:

_____

_____

_____