Boundary Wellness Center
Patient Intake Form

47-8 Boundary Ave, South Farmingdale, N.Y. 11735
(T) 516-694-1590 (F) 516-249-8213

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment. Please print out this form and bring the completed form to your first appointment.

First Name ___________________ Middle Initial ____ Last Name __________________________

Address ____

City _______________________________ State ___________________ Zip Code ______________

Home Phone (_____) ________-___________ Work Phone (_____) _________-_____________

Cell Phone (_____) ________-___________Email ___________________________________

Date of Birth ______/______/_______ Sex: Male Female

Marital Status: Single Married Other

Spouse Data ____

First Name ___________________ Middle Initial _____ Last Name _________________________

Home Phone (_____) _______-___________ Work Phone (_____) _________-____________

How did you hear about our office? ____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _______________			

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular	Cervical spine	Hysterectomy
Cranial/Brain	Shoulder	Thoracic spine	Urogenital
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Carpal Tunnel	Gastrointestinal	Knee	Hernia
Other _______________			

Please give a brief description of the problem[s] you are experiencing:

____

____

When did the problem start? ____

Is/Are the problem[s] getting better? Yes No or getting worse? Yes No

What appears to be the initial cause? ____
____
____

What types of treatment(s) did you receive for your condition? (Circle all that apply)

Chiropractic Physiotherapy Acupuncture Massage Surgery Pharmaceuticals Epidural

Complaint Location: ____

Onset: Acute Chronic Gradual

Quality: Achy Dull Stiff Tight Sharp Throbbing

Range: How does it feel at its best? (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

How does it feel at its worst? (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

Place an X next to "yes" or "no" to indicate if you have had any of the following:

Aids/HIV	___yes ___no	Glaucoma	___yes ___no	Pinched Nerve	___yes___no
Alcoholism	___yes ___no	Gonorrhea	___yes ___no	Pneumonia	___yes___no
Allergy shots	___yes ___no	Goiter	___yes ___no	Polio	___yes___no
Anemia	___yes ___no	Gout	___yes ___no	Prostate Problems	___yes___no
Anorexia	___yes ___no	Heart Disease	___yes ___no	Prosthesis	___yes___no
Appendicitis	___yes ___no	Hepatitis	___yes ___no	Psychiatric Care	___yes___no
Arthritis	___yes ___no	Hernia	___yes ___no	Rheumatoid Arthritis	___yes___no
Asthma	___yes ___no	Herniated Disc	___yes ___no	Rheumatic Fever	___yes___no
Bleeding Disorders	___yes ___no	Herpes	___yes ___no	Scarlet Fever	___yes___no
Breast Lump	___yes ___no	High Cholesterol	___yes ___no	STD's	___yes___no
Bronchitis	___yes ___no	Kidney Disease	___yes ___no	Stroke	___yes___no
Bulimia	___yes ___no	Liver Disease	___yes ___no	Suicide Attempt	___yes___no
Cancer	___yes ___no	Measles	___yes ___no	Thyroid Problems	___yes___no
Cataracts	___yes ___no	Migraine	___yes ___no	Tonsillitis	___yes___no
Chemical Dependency	___yes ___no	Miscarriage	___yes ___no	Tuberculosis	___yes___no
Chicken Pox	___yes ___no	Mononucleosis	___yes ___no	Tumors, Growths	___yes___no
Diabetes	___yes ___no	Multiple Sclerosis	___yes ___no	Typhoid Fever	___yes___no
Emphysema	___yes ___no	Mumps	___yes ___no	Ulcers	___yes___no
Epilepsy	___yes ___no	Osteoporosis	___yes ___no	Vaginal Infections	___yes___no
Fracture	___yes ___no	Pacemaker	___yes ___no	Whooping Cough	___yes___no
Hand Dominance	_____R____L	Parkinson's	___yes ___no	Other: ____________________	