Advanced Laser Therapy and Wellness, LLC

Intake Form

Dr. Brian Harasha

Name: _____ Gender ID: _____ Date: _____

Address: _____ Phone: #1 h-c-w _____

City: _____ MO / IL Zip:_____ #2 h-c-w _____

E-Mail: _____ Occupation: _____

Date of birth: _____ Age: ____ Marital Status: _____ # of children: _____

Do you have health insurance? ___ If yes, please give company name and policy / group number:

_____

How did you hear about our office? _____

Physical History

Have you ever been examined by a Chiropractor or Acupuncturist? Y / N If Y, when? _____

Have you ever been in a vehicular collision or near collision? Y / N - If Y, when? _____

Were you ever knocked unconscious or broken any bone? Y / N If Y, when? _____

Have you had any other significant injuries? Y / N If Y, when: _____ Describe:_____

_____

Do you:	Read for prolonged periods of time?	Y / N Hours/week? ____
	Work or play in front of a screen for prolonged periods?	Y / N Hours/week? ____
	Exercise at home/gym/outside?	Y / N Hours/wekk? ____
	Participate in active sports? Y / N If Y, which one(s)?	_____

Have you had surgery? Y / N If Y, when and what was done? _____

_____

Have you ever been hospitalized for reasons besides surgery? Y / N If Y, explain when and for what

_____

Chemical History

General Chemical Trauma

Are you now taking any prescription or over-the-counter medication regularly? Y / N

Drug / OTC / Supplement	Reason
_____	_____
_____	_____
_____	_____

When was your last visit to the doctor who prescribed them? _____

Do you work with any chemicals, fumes, dust or smoke for prolonged periods? Y / N

Personal Health Information

Are you healthier now than you were 5 years ago? Yes ____ No ____ Explain: _____

_____

Will you be healthier in 5 years than you are now? Yes ____ No ____ Explain: _____

_____

On a scale of 1 -5 (1=poor, 5=great), how do you rate your Physical health? ___ Mental health? ___

If pain is the chief complaint, please circle all that apply: Headache Neck Shoulder Elbow/wrist/hand

Fingers/Toes Mid Back/Ribs Low Back SI Joint Buttock Hip Knee Ankle/Foot Other/Side: _____

Is this pain: Stationary OR Radiates *(travels)* into: _____

Quality (describe the sensation–dull/achey/burning/stabbing/trobbing,etc.):_____

If chief complaint is not pain, please describe: _____

_____

When or how did it start?: _____

For ANY complaint:

Palliative (what have you tried to make it better): _____

Provocative (what makes it worse): _____

Severity (on a scale of 1-10, 10 being worst pain ever): Today: _____ On Average: _____

Timing (does it change, get better or worse throughout day): _____

Health History (have You or a Family member *(parents, siblings, grandparents)* ever had):

Cardiovascular (heart disease, high blood pressure, cholesterol, etc.): You: _____
Relative: _____

Respiratory (lung disease, asthma, pneumonia, smoking, etc.) You: _____
Relative: _____

Digestive (ulcer, irritable bowel, sensitivities, etc): You: _____
Relative: _____

EENT (eyes, ears, nose, throat): You: _____
Relative: _____

Neurological (dizziness, seizures, dementia, stroke, etc): You: _____
Relative: _____

Urogenital (kidney, urination, infections, etc): You: _____
Relative: _____

Reproductive (ED, prostate, ovaries, infertility, etc.): You: _____
Relative: _____

Musculoskeletal (muscle/bone/joint disease, broken bones, etc.): You: _____
Relative: _____

Skin, vessels (rashes, infections, clots, varicosities, etc.): You: _____
Relative: _____

Cancer (any kind): You: _____
Relative: _____

Other (diabetes, headaches, etc.): You: _____
Relative: _____