NEW PATIENT INTAKE

PATIENT INFORMATION

PATIENT NAME: ______________________

AGE: __________ SEX: M / F DATE OF BIRTH: __________

PLEASE LIST YOUR CURRENT PAIN CONCERNS (LIST IN ORDER OF SIGNIFICANCE)

1 ______________________

2 ______________________

3 ______________________

4 ______________________

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS (INCLUDE DOSAGE and FREQUENCY)

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PLEASE LIST ALL SUPPLEMENTS YOU ARE CURRENTLY TAKING (INCLUDE DOSAGE and FREQUENCY)

(INDICATE SELF PRESCRIBED (S) OR PRESCRIPED BY A HEALTH CARE PROFESSIONAL (P)

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PLEASE LIST ALL HEALTH CARE PROVIDERS CURRENTLY TREATING YOU

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PLEASE LIST ALL KNOW ALLERGIES TO THE FOLLOWING

MEDICATIONS: ______________________

FOODS: ______________________

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