

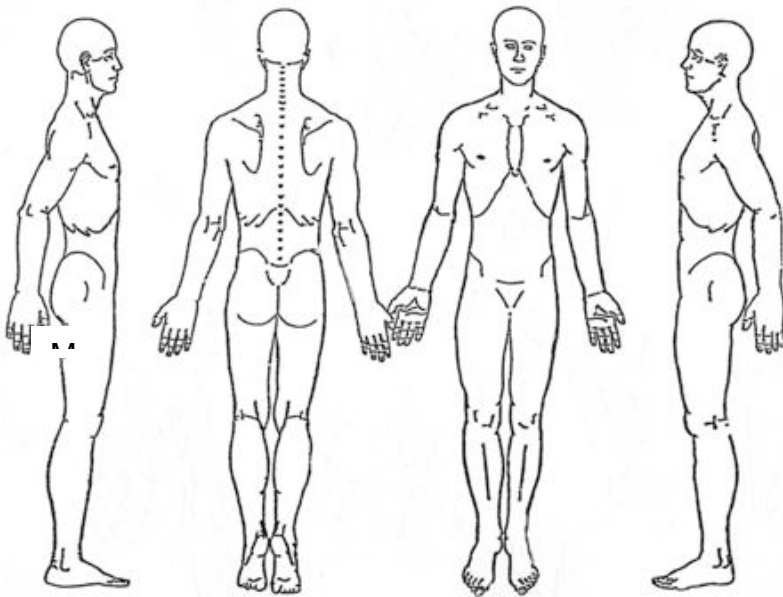
Cheryl Sly, NMD  
Patient Intake Sheet

**Patient information**

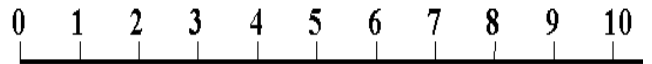
Name:	Today's Date:	
Street	Home Phone: ( )	
City:	Work Phone:( )	Cell Phone:( )
State:	Date of Birth:	Age:
Zip:	Weight:	Height:
Employer:	Who referred you?	
Your Occupation:	Who is your primary care doctor?	

**What is the medical reason you are seeing the doctor?**

Mark your areas of pain



What is your pain level today?



No Pain

Worst Pain

What does the pain feel like?

- Dull
- Throbbing
- Burning
- Shock-like
- Sharp
- Other (describe)

**Medications:**

**Allergies:**

**Past surgical history (please list all surgeries and dates):**

Dr

**Review of medical history (please mark all appropriate boxes):**

**General**

- |  |                                   |  |
|--|-----------------------------------|--|
| <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Low sex drive |
| <input type="checkbox"/> Fevers                    | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Alcohol (Quantify _____ ) | <input type="checkbox"/> Weakness | <input type="checkbox"/> Diabetes      |
|  | <input type="checkbox"/> Tremors  | <input type="checkbox"/> Other:        |

**Head, Eyes, Ears, Nose and Throat**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Eye problems     | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Dental problems  |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Sinus problems         | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Nose bleeds            | <input type="checkbox"/> Head injury      |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Other:           |

**Cardiovascular**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chest pain       | <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Swelling in feet     | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart attack     | <input type="checkbox"/> MVP                  | <input type="checkbox"/> Valve replacement   |
| <input type="checkbox"/> Murmur           | <input type="checkbox"/> Phlebitis            | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Other: _____        |

**Respiratory**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Wheezing                | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Pneumonia    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Valley Fever    | <input type="checkbox"/> Cough        |
| <input type="checkbox"/> Smoking (packs/day____) | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Tuberculosis |
|  | <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Other: _____ |

**Gastrointestinal**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Abd. cramps                  | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Acid reflux     | <input type="checkbox"/> GI bleeding from medications | <input type="checkbox"/> Other: _____ |

**Musculoskeletal**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Back pain            | <input type="checkbox"/> Tennis elbow           |
| <input type="checkbox"/> Joint pain     | <input type="checkbox"/> Muscle spasms        | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Bursitis               |
|   | <input type="checkbox"/> Joint injury         | <input type="checkbox"/> Other: _____           |

**Renal**

- |                                   |   |  |
|-----------------------------------|---|--|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney infections  | <input type="checkbox"/> Kidney problems |
|                                   | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Other: _____    |

**Hepatic**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Hepatitis (Active? _____ ) | <input type="checkbox"/> Other: _____ |
|---|---------------------------------------|

**Neuropsychological**

- |   |   |
|---|---|
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Stress problems  | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Other: _____       |

Patient Name/DOB:

Family medical history:

Which family member(s)?

- Headaches \_\_\_\_\_
  - Heart disease \_\_\_\_\_
  - Stroke \_\_\_\_\_
  - Diabetes \_\_\_\_\_
  - High blood pressure \_\_\_\_\_
  - Increased cholesterol \_\_\_\_\_
  - Arthritis \_\_\_\_\_
  - Rheumatoid arthritis \_\_\_\_\_
  - Kidney problems \_\_\_\_\_
  - Liver problems \_\_\_\_\_
  - Seizures \_\_\_\_\_
  - Osteoporosis \_\_\_\_\_
  - Cancer \_\_\_\_\_
  - Other medical problems: \_\_\_\_\_
-

