ashtonhealth
A NEW PARADIGM IN ORTHOPEDIC CARE

INTAKE FORM

PERSONAL INFORMATION

Last name _____ First name _____

Date of Birth / Age _____

Living address: _____

City _____ State _____ Zip _____

Best phone number to contact you _____

**Email Address _____

** Emergency Contact _____ Cell phone/home phone _____

** Occupation (s) _____

_____

Hobbies _____

_____

Name of Referral: _____

How did you learn of my practice? _____

MEDICAL HISTORY

**List name of all surgeries you have had and surgeon/MD for the procedures/surgeries

1) _____

2) _____

3) _____

4) _____

5) _____

**List of all medications and purpose:

1) _____

2) _____

3) _____

Do you have x-rays/MRI's/scans? ☐ Yes ☐ No

*Please provide a write up and a "photo" of the scan at the appointment.

Are you currently or have you received injections: botox, epidural, Trigger Point, Cortisone? ☐ Yes ☐ No

If so, please circle injection type.

Are injections helping? ☐ Yes ☐ No

Please indicate body part and physician you are seeing for injections: _____

_____

Are you pregnant? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Have you ever received a "Medical Massage?" ☐ Yes ☐ No

Regular Massage? ☐ Yes ☐ No

Do you have a prescription for medical massage? ☐ Yes ☐ No

Do you see a Physical Therapist? ☐ Yes ☐ No Name _____

Chiropractor? ☐ Yes ☐ No Name _____

PAIN/INJURY INFORMATION

Please list your problem areas and location of symptoms (Pain, tightness, numbness, burn, ache) that you wish for me to treat today:

1) _____

2) _____

3) _____

4) _____

Do you have Autoimmune Diseases? ☐ Yes ☐ No

If yes, please list: _____

_____

On a scale of 0-10, please rate the pain level you have and where; minimum to maximum.

0 1 2 3 4 5 6 7 8 9 10

☐ Sleeping on side or back ☐ Driving ☐ Exercise ☐ Bending over to tie shoes

☐ Sitting at a desk for length of time ☐ Phone usage ☐ Running / walking _____

☐ Standing for short or long periods of time ☐ Other

List activities that provide relief: _____

_____

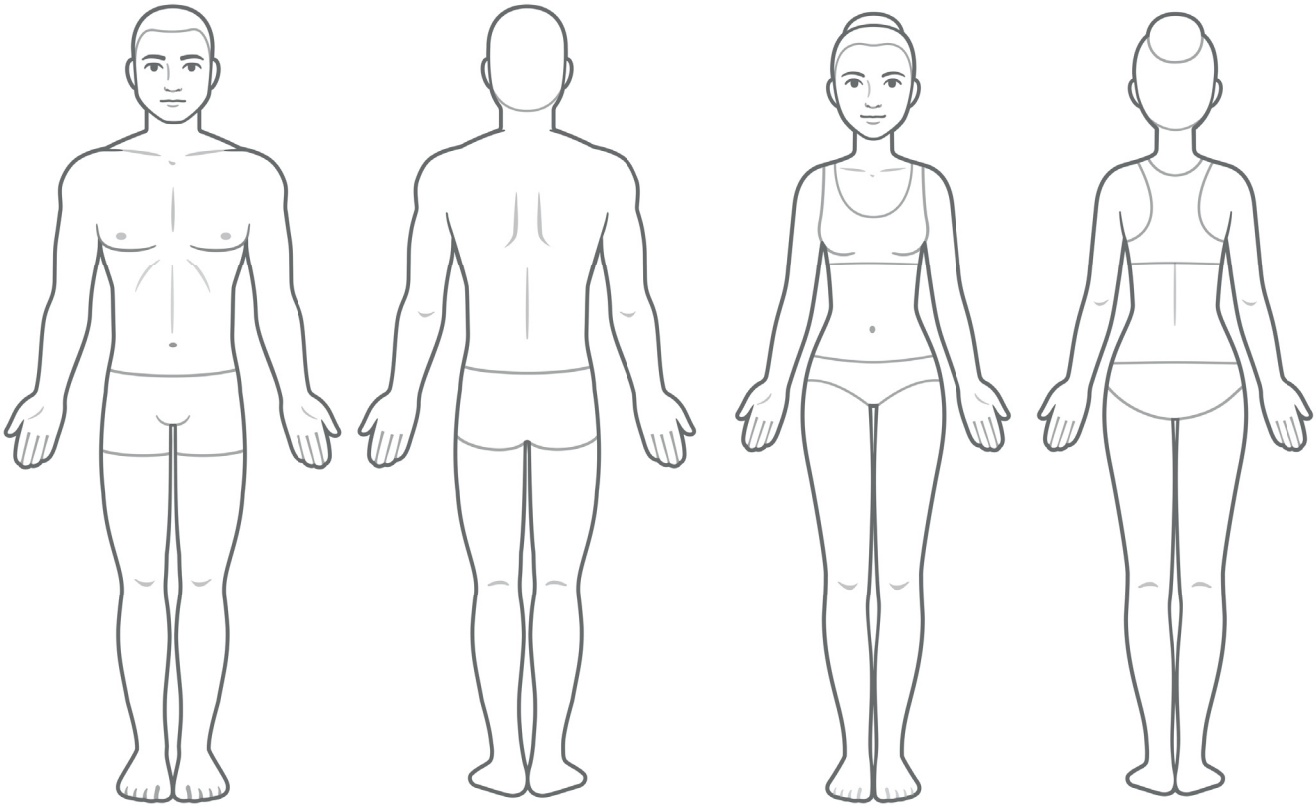
Do you perform stabilization or strengthening exercises at home on a regular basis? ☐ Yes ☐ No

Have you ever received cupping/Rock Tape/Gua-Sha (Graston) before? ☐ Yes ☐ No

What are your goals and how do you plan on achieving them?_____

_____

Please circle/point and state type of symptom you are experiencing:



COVID-19 INFORMATION

Have you been exposed to anyone recently that tested positive for COVID-19? ☐ Yes ☐ No

Are you wearing masks and social distancing? ☐ Yes ☐ No

Please provide date of last vaccine: _____