Wellness From Within, LLC
Intake Form

Personal Information

Name: _____Today's Date: _____/_____/_____
Address: _____City, State_____Zip_____
E-Mail Address: _____
Birth Date: _____/_____/_____ Age: _____
If Female, Are You Pregnant: __Yes __No
Occupation:_____
Cell Phone No.: _____Home Phone No.: _____
Referral Source: _____ May I thank them?: ___ Yes ____No

Health History

In order of importance, list the health problems you are most interested in addressing:

1._____
2._____
3. _____
4._____
5._____

Please list any diagnosis and type of treatment you have received (please include where and when you received treatment, and the results):

_____
_____
_____
_____

During the last year, has a doctor treated you for any health problem? ___Yes ___No
If yes, please explain: _____
_____
Has your health problem(s) been: ___Improving ____Worsening ___Staying the Same

List the approximate dates of any operations or serious injuries (including broken bones) you have had: _____
_____
_____

Please describe anything you do that improves your condition, or worsens it:_____
_____
_____

Kirstin Colligan, P.T.
www.wellnessfromwithinwi.com
262-210-0845

Wellness From Within, LLC
Intake Form

Please describe how this problem interferes with your work and/or personal life:
Home Activities Affected:_____
Work Activities Affected: _____
Recreational Activities Affected: _____
Rest or Sleep Affected: _____

Please check the medications you are now taking: __Pain Killers __Muscle Relaxers
__Anti-inflammatory __Blood Pressure Drugs __Cholesterol Drugs __ Insulin
__Birth Control Pills __Diet Pills __Nerve Medication
__Sleeping Pills __Depression Drugs __Other

Please check if you have the following symptoms: Use "P" if had in the past.

__HEADACHES	__PINS AND NEEDLES IN LEGS	__LOSS OF SMELL
__NECK PAIN	__NUMBNESS IN FINGERS	__LOSS OF TASTE
__SLEEPING PROBLEMS	__NUMBNESS IN TOES	__DIGESTIVE PROBLEMS
__BACK PAIN	__SHORTNESS OF BREATH	__FEET COLD
__ANXIETY	__FATIGUE	__HANDS COLD
__TENSION	__DEPRESSION	__STOMACH UPSET
__IRRITABILITY	__LIGHTS BOTHER EYES	__CHEST PAINS
__LOSS OF MEMORY	__COLD SWEATS	__DIZZINESS
__EARS RING	__LOSS OF BALANCE	__FEVER
__NECK STIFF	__FAINTING	__LOW ENERGY
__FOOT PAIN	__ANKLE PAIN	__KNEE PAIN
__HIP PAIN	__SHOULDER PAIN	__ELBOW PAIN
__WRIST PAIN	__JAW PAIN	__ALLERGIES

Do you Smoke? __Yes __No
Do you drink alcohol? ___ No __Socially __More than Socially
Do you have a pacemaker? __Yes __No
Do you have a root canal? __Yes __No
Do you have amalgam (silver) fillings? __Yes __No
Do you have any known contraindications to increased cerebrospinal fluid pressure?__Yes__No
Do you have known allergies? __Yes __No If yes, to what? _____
_____
Anaphylactic allergies? ___Yes ___No
If yes, to what?_____
_____

Thank you for helping update your health information!

Kirstin Colligan, P.T.
www.wellnessfromwithinwi.com
262-210-0845

Wellness From Within, LLC
Intake Form

Kirstin Colligan, P.T.
www.wellnessfromwithinwi.com
262-210-0845