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MEDICAL INTAKE FORM

Patient _____

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :

- | | | | | | |
|-------------------------------|-----|----|--------------------------------|-----|----|
| 1. High Blood Pressure | yes | no | 28. Blood in Stool / Ulcers | yes | no |
| 2. Heart Disease Heart Attack | yes | no | 29. Abdominal Pain | yes | no |
| 3. Chest Pains / Angina | yes | no | 30. Thyroid Problems | yes | no |
| 4. High Cholesterol | yes | no | 31. Polio / Muscle Disease | yes | no |
| 5. Pacemaker | yes | no | 32. Seizures | yes | no |
| 6. Shortness of Breath | yes | no | 33. Migraine/Cluster Headaches | yes | no |
| 7. Asthma | yes | no | 34. TMJ Disorders | yes | no |
| 8. Allergies | yes | no | 35. Chills/Fever/Sweats | yes | no |
| 9. Chronic Bronchitis | yes | no | 36. Chronic Headaches | yes | no |
| 10. Blood Disorders | yes | no | 37. Swelling of Extremities | yes | no |
| 11. Emphysema | yes | no | 38. Sleep Disorders | yes | no |
| 12. Bleeding/Bruising | yes | no | 39. Depression | yes | no |
| 13. Anemia | yes | no | 40. Fibromyalgia | yes | no |
| 14. Diabetes | yes | no | 41. Chronic Fatigue Syndrome | yes | no |
| 15. Hypoglycemia | yes | no | 42. Lyme's Disease | yes | no |
| 16. Lightheadedness | yes | no | 43. Chronic Pain | yes | no |
| 17. Dizziness | yes | no | 44. Night Pain | yes | no |
| 18. Concussion | yes | no | 45. Unexplained Pain | yes | no |
| 19. Fainting Disorders | yes | no | 46. Unexplained Weight Loss | yes | no |
| 20. Anxiety/Panic Attacks | yes | no | 47. Cancer/Tumors/Growths | yes | no |
| 21. Arthritis/Joint Pain | yes | no | 48. History of Smoking | yes | no |
| 22. Artificial Joints | yes | no | 49. Are you pregnant? | yes | no |
| 23. Kidney Disease/Stones | yes | no | 50. Gynecological Disorders | yes | no |
| 24. Hepatitis | yes | no | 51. Bladder Incontinence | yes | no |
| 25. Spinal Cord Injury | yes | no | 52. Bowel Incontinence | yes | no |
| 26. Traumatic Brain Injury | yes | no | 53. Fractures | yes | no |
| 27. Ulcers | yes | no | | | |

Date: _____ Area: _____

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CURRENT MEDICATIONS: _____

SIGNATURE: _____ Date: _____