Care
FAMILY HEALTH NP, PLLC

New Member Intake Form

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Address: _____ DOB: _____

City: _____ State: _____

Phone: _____ Email: _____

Occupation: _____ Marital Status: _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Number: _____

Relationship: _____

CURRENT CONCERNS

Primary Complaint: _____

Onset Date: _____ Has it changed since onset? ☐ Same ☐ Better ☐ Worse

Pain description: ☐ Aching ☐ Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Burning ☐ Other:

Pain intensity (0–10): _____

How it affects daily activities: _____

Secondary Complaint: _____

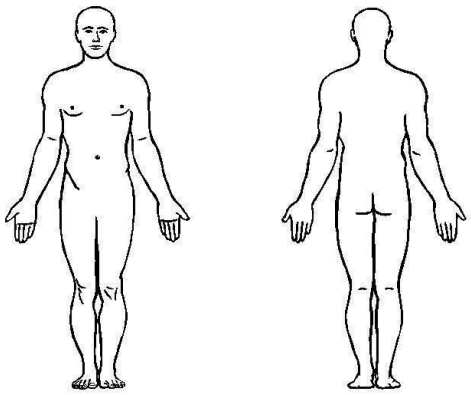
Onset Date: _____ Has it changed since onset? ☐ Same ☐ Better ☐ Worse

Pain description: ☐ Aching ☐ Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Burning ☐ Other:

Pain intensity (0–10): _____

How it affects daily activities: _____

Mark corresponding concern areas:



CURRENT STATUS

Do you have a Pacemaker: ☐ Yes ☐ No

Are you Pregnant (Female only): ☐ Yes ☐ No

Do you have a current active cancer diagnosis: ☐ Yes ☐ No

In the last 48hrs, have you taken any NSAIDs? (Advil/Ibuprofen, Meloxicam, Voltaren/Diclofenac, Naproxen, Celebrex, etc.) ☐ Yes ☐ No _____

In the last 3mo, have you had epidurals, cortisone, or other steroid injections: ☐ Yes ☐ No

In the last 3mo, have you taken any oral steroids (Prednisone, Methylprednisolone, Dexamethasone, Triamcinolone, Betamethasone): ☐ Yes ☐ No

MEDICAL HISTORY

• Current Medications/Supplements:

_____

_____

• Past Surgeries / Hospitalizations:

_____

_____

• Major Accidents or Injuries:

_____

_____

• Serious Illnesses / Diagnoses:

_____

_____

Circle any health conditions that apply to you:

Sub-Clinical Symptoms:
- Headaches
- Migraines

Hormone Imbalance:
- PMS
- Emotional imbalance

Gastrointestinal Issues:
- Abdominal bloating
- Cramps or painful gas
- Irritable Bowel Syndrome
- Ulcerative Colitis
- Crohn's Disease and other intestinal disorders

Respiratory Conditions:
- Chronic sinusitis
- Asthma
- Allergies

Joint Conditions:
- Knee, Shoulder, or Spine

Autoimmune Conditions:
- Diabetes Mellitus
- Lupus
- Rheumatoid Arthritis
- Fibromyalgia
- Chronic Fatigue

Thyroid Conditions:
- Hashimoto's
- Hypothyroidism
- Hyperthyroidism

Developmental and Social Concerns:
- Autism
- ADD/ADHD

Skin Conditions:
- Eczema
- Skin rashes
- Hives

How has your health condition/pain affected your job, relationships, finances, family, and other activities?

_____

_____

What has that cost you? (Time, money, sleep, promotions, etc.)

_____

_____

What are you most concerned about regarding your problem/pain?

_____

_____

Where do you picture yourself in the next 1-3 years if this problem is not taken care of?

_____

_____

What would be different/better without this problem?

_____

What would that mean to you?

_____

Consent For SoftWave Therapy

RISK OF THIS PROCEDURE

A) Pain and soreness. This is temporary and usually resolves after a few days.

B) The FDA has labeled this a “Non-Significant Risk” therapy for cleared Indications.

CONSENT FOR PROCEDURE

I, _____ , consent to ESWT for addressing the area of:

_____

I have been informed about Extracorporeal Shockwave Therapy (ESWT) and understand its purpose, benefits, and potential outcomes as explained by my physician/staff. I have had the chance to ask questions, and no guarantees have been made regarding pain relief or improved function.

Signed _____ Date: _____