Healing The Generations, Inc

# GROUPON NEW PATIENT INTAKE FORM

Name:_______________________________________ Date:____________________

Phone:___________________ Email address:________________________________

Address:_______________________________________________________________

DOB: ________________ Groupon #:__________________________

Reasons for consult and complains:_________________________________________

_____________________________________________________________________

_____________________________________________________________________

Medical history and medications: ___________________________________________

_____________________________________________________________________

_____________________________________________________________________

Pain Level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (most severe):_______________________

_____________________________________________________________________

What eases the pain:_____________________________________________________

What worsens the pain:___________________________________________________

Sleep quality: 0 (worse) 1 2 3 4 5 6 7 8 9 10 (best)

Energy level: 0 (none) 1 2 3 4 5 6 7 8 9 10 (great)

Stress Level: 0 (never) 1 2 3 4 5 6 7 8 9 10 (always)

Current or past therapy/medical care for this condition :__________________________

_____________________________________________________________________

_____________________________________________________________________