ANATOMY IN MOTION
PATIENT INTAKE FORM

(Please Print)

Today's Date:	PCP: 101

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no:	Phone : ( )

P.O. box:	City:	State:	ZIP Code:

Email:	Employer:	Employer phone: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Employer	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

BILLING INFORMATION & REASON FOR CARE

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient Medicare? ☐ Yes ☐ No

Please indicate primary interest in care?	☐ Wellness	☐ Pain Relief	☐ Postural Correction	☐ Athletic Performance	☐ Flexibility

☐ Behavior	☐ Sleep Disturbance	☐ Digestive	☐	☐ Other

Primary area of concern:	Acute / Chronic :	Since date:	Related issues:	Related to Trauma:	Satisfied:

Describe pain: ☐ Ache ☐ Burn	☐Throbbing	☐ Tingling	☐ Numbness	☐ Localized ☐ Radiating	Rate :_____

Secondary concern:	Systems involved:	Seen other Provider/s?:	Satisfied w/ Care? :

Patient:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. *I understand that I am financially responsible for any balance.* (_____) I also authorize **Anatomy In Motion** to release any information required to collect any unpaid balance.

Patient/Guardian signature *Date*