# Patient Intake Form

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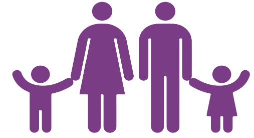

Where Patients Come First

## Patient Information:

First Name: ____________________

Last Name: ____________________

DOB: ____________ Gender: ______

HC #: ____________ VC: ______

Telephone: ____________________

Address: ____________________

## Physician Information:

Physician Name: ____________________

Physician Signature: ____________________

Physician Billing #: ____________________

Telephone: ____________________

Fax: ____________________

Address: ____________________

## Reason For Consultation

- ☐ Chronic Pain
- ☐ Cancer
- ☐ Gastrointestinal Issues
- ☐ Sleep Disorders
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Migraine Headache
- ☐ Spinal Injuries
- ☐ Other: ____________

## Current Medications

## Relevant Investigations

## Additional Information