Jamin D. Rak, L.M.T.

Intake Form

10552 NE Glisan St - Portland, OR 97220

Phone: (503) 314-8365

Patient Information

Name: _____ Date: ___ - ___ - ___
Last First M.I.

Address: _____
Number Street City State Zip

Phone: ( ) ( ) Referred By: _____
Home Work or Cell

Email: _____ @ _____

Insurance Co. _____ Phone: ( ) _____

Address: _____
Number Street City State Zip

Adjuster: _____

Insured: _____ Relation: _____
if other than patient Last First M.I.

Date of Injury: ___ - ___ - ___

Policy #: _____ D.O.B.: ___ - ___ - ___

Claim #: _____ SS #: ___ - ___ - ___

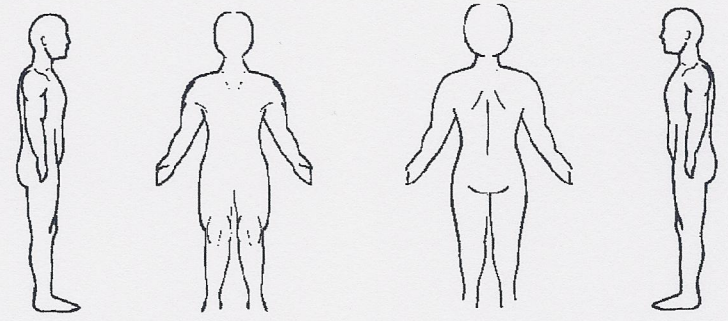
Symptoms:

What activity is difficult:

Sitting Standing Walking Running Bending Lifting Twisting Lying Down

Please mark your type of pain with location on diagram:

Shooting
Burning
Throbbing
Tingling
Numb
Dull
Stiff
Sharp



Right Side Front Back Left Side

Shooting
Burning
Throbbing
Tingling
Numb
Dull
Stiff
Sharp

Health History:

Circle any of the following that you have or have had in the past:

Heart Disease	Arthritis	Asthma	Cancer	Diabetes	Emphysema	Herniated Disc
Pinched Nerve	Fractures	Hepatitis	Strains	Sprains	Stroke	High Blood Pressure
Osteoporosis	Epilepsy	Migraine	AIDS/HIV	Headaches	Other: _____	

Are you taking any medications? _____ Are you pregnant? _____

If yes, what medications are you taking? _____ Due date? _____

I certify that the above answers have been answered accurately and if there are any changes in the future to my health I will inform the therapist immediately.

Signature: _____ **Date:** _____