NEW PATIENT INTAKE

Welcome to our office. We appreciate the confidence you place with us to provide chiropractic care. To assist us in serving you better, please complete the following form. If you have any questions, don't hesitate to ask.

Personal Information:

First Name _____ Last Name _____
Preferred Name _____ Middle Initial_____
Address _____
City_____ State _____ Zip Code _____
Cell Phone _____ Home Phone _____
Email Address _____

Permission to contact you by email and/or text message regarding appointment reminders or other clinic related

details. ☐YES ☐NO
Date of Birth_____
Age _____
Gender ☐Male ☐Female Marital Status: ☐S ☐M ☐D ☐W
Spouse's Name _____Number of Children _____
Occupation _____ Employer _____
Emergency Contact _____Phone _____

Referral Information:

Who may we thank for referring you? _____
How did you hear out about us? _____
Primary Care Physician (Name & Location)
_____
Permission to contact your primary care physician regarding your care at our office? ☐YES ☐NO

GENERAL HEALTH INFORMATION

Current Height: _____ Weight: _____
Medications:_____
Vitamins/Herbs/Minerals: _____
Allergies :_____
Pregnancy Due Date: _____

Personal Health History

☐Unexplained Weight loss
☐Cold limbs
☐Thyroid
☐Night Pain
☐Depression
☐Night Sweats
☐Diabetes
☐Bowel or Bladder Changes
☐Digestive Issues
☐AIDS/HIV
☐Heart Disease
☐Anemia
☐High Blood Pressure
☐Arthritis
☐Headaches
☐Asthma
☐Liver Disease
☐Bleeding disorder
☐Lung Disease
☐Breast Lump
☐Neurological
☐Cancer
☐Osteoporosis
☐Chem. Dependency
☐Prostrate Issues
☐Chest Pain
☐Stroke
☐Other

-Please Continue on Page 2-

Injuries/Surgeries/Accidents: **Description** **Date**

Auto Accidents: _____ _____

Broken Bones: _____ _____

Surgeries (including Cosmetic): _____ _____

Social History/Habits:

Do you use Tobacco products? ☐Yes ☐No ☐Past If yes, how many packs per day? _____

Do you drink alcoholic beverages? ☐Yes ☐No If yes, how many drinks per week? _____

Do you drink caffeinated beverages? ☐Yes ☐No If yes, how many drinks per week? _____

Do you exercise? ☐Yes ☐No
If yes, how many days per week and what activity? _____

Family History:
Has any member of your Parents or Sibling's suffered from:
High Blood Pressure, High Cholesterol, Cancer, Osteoporosis, Diabetes, Stroke, Heart Disease or Thyroid conditions?

If yes, who and what condition?

_____

PATIENT CONDITION

Onset

Describe your major complaint(s): _____

Describe when they began: _____

Date you first noticed your symptoms: _____/_____/_____

Do your symptoms radiate or travel? If so, where to?

_____

Timing and Duration:

How are your symptoms changing?
☐Getting Better ☐Getting Worse ☐No Change

How often do you experience your symptoms?

☐Constant (100%) ☐Frequently (75%) ☐Occasionally (50%) ☐Intermittently (25%)

How have your symptoms interfered with your normal work or activities?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐extremely

How much have your symptoms affected your social or recreational activities?

☐None of the time ☐A little of the time ☐Some of the time ☐Most of the time ☐All of the time

Severity:

How would you rate your symptoms at their:

	None									unbearable
Best:	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Worst:	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Quality:

How would you describe your symptoms?

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Weakness ☐ Dull ☐ Burning
☐ Stiffness ☐ Throbbing ☐ Achy ☐ Tingling ☐ Numbness ☐ Other

Modifying Factors:

What makes your symptoms feel worse?

☐ Cough/Sneezing ☐ Standing ☐ Lifting ☐ Exercising ☐ Bending
☐ Twisting ☐ Driving ☐ Sitting ☐ Walking ☐ Pushing/Pulling ☐ Other

What makes your symptoms feel better?

☐ Rest/Sleeping ☐ Stretching ☐ Lifting ☐ Exercising ☐ Bending
☐ Pain Medication ☐ Twisting ☐ Ice ☐ Heat ☐ Walking ☐ Other

Previous Treatment:

Who have you seen for this condition?

☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ Other_____

What tests have been performed? Date?

☐ X-Rays_____ ☐ CT Scan_____ ☐ MRI_____ ☐ Lab_____ ☐ Other _____

Have you had Chiropractic care in the past? ☐ YES ☐ No

If yes, for what? _____