



PATIENT INTAKE

This information is confidential. If, after gathering the necessary information we do not believe your problem will respond favorably with chiropractic care, we will discuss our findings with you and make the necessary referrals or recommendations. In order for us to fully understand your health problems and be able to give you our best care and advice, please complete this form neatly, accurately, and thoroughly. Thank you.

Legal Name: First _____ Middle _____ Last _____
 Preferred or nickname _____ Today's Date ____/____/____ Date of Birth ____/____/____
 Local address _____ City _____ State _____ Zip _____
 Other address _____ City _____ State _____ Zip _____
 Home Phone(____)____-____ Work Phone(____)____-____ Cell Phone(____)____-____
 E-Mail _____ Sex: Male Female Height ____'____" Weight _____ lbs
 SS# _____ - _____ - _____ If patient is a minor name of parent or guardian _____
 relationship _____ Address Same as above _____
 Emergency contact _____ relationship _____ Phone(____)____-____
 Referred by _____ Your primary care physician: _____

Current Complaints	Date of Onset	Probable cause

History of Current Complaints None If this is a recurrent problem please describe the **initial cause**, the frequency, how you have treated in the past, and if past treatment was successful:

NONE For the PRESENTING CONDITION and OTHER CURRENT CONDITIONS which you are treating, please list ALL providers, treatments and outcomes

Recommended by Self / Doctor / therapist	Treatment / Testing PT, exercises, medications, ice, heat, x-ray, MRI, CT, labs	Outcome partial or temp relief, no help, etc.

NO Have you received care from a Chiropractor in the past?

Who & Where	When & Reason	Outcome

<input type="checkbox"/> NONE Please list any other <u>serious</u> illnesses or conditions which you have been diagnosed and/or treated (cancer, heart, diabetes, mental, TB, high blood pressure, high cholesterol, HIV, asthma etc.)			
Condition	Date diagnosed	Treatment – if hospitalized please write <u>H</u>	Outcome

<input type="checkbox"/> NONE prescription or over the counter medications AND supplements you are currently taking					
Name	Reason	Dosage	Frequency	How long	Side effects

<input type="checkbox"/> NONE Please list all significant trauma (auto, lifting, fracture, dislocation, sport)				
Type of trauma	Date	Body parts injured	Treatment please if hospitalized write <u>H</u>	Residual problems

<input type="checkbox"/> NONE Please list all surgeries or prostheses			
Surgery if hospitalized please write <u>H</u>	Date	Surgeon & location	Results

<input type="checkbox"/> NONE Please list any Allergies		
Food	Environmental	Medications

<input type="checkbox"/> NONE	Mother	Father	Sister	Brother	Grand mother	Grand father	Child
Family History							
Cancer							
Heart							
Diabetes							
Kidney							
Autoimmune							
Hereditary							
Psychiatric							
Other							

Do you wear heel lifts or sole lifts in shoes - No right left both
Who prescribed _____ date _____

WORK HISTORY

Present occupation _____ Retired from _____

Employer _____ Job description _____

Presently unemployed – Unemployment due to injury Y N Explain _____

Disability: N Y date _____ By whom _____ Due to _____

Work restrictions none Y By whom _____ starting date _____
total lost days _____ Define: _____

With past and/or present job were/are you exposed to: dust coal other airborne particles
 toxic fumes other _____ From _____ to _____

SOCIAL HISTORY

Marital Status S M W D Sep Name of Spouse _____

No. of Children _____ No children Ages _____ **Currently pregnant** Y N possibly

Tobacco use: cigarettes cigars smokeless Pk-can./day years

never non-user since _____ but when used Pk-can./day years

Alcohol consumption: never rare daily days per week recovering alcoholic

Caffeine coffee tea soda cups/day Recreational drug use: none _____

Exercise: I do not exercise on a regular schedule.

My exercise consists of _____ times per week _____ for _____ minutes

Stress level: currently rated (select one) high medium low: major stress factors _____

Highest level of Education (select one): Grade School Middle School HS GED Vocational School
 Undergraduate College Graduate College

Sleeping posture (select all that apply): back sides stomach

Diet: vegan vegetarian well balanced could use some help could use lots of help

Average number of serving of fruits and vegetables per day

Review of Systems: Please check the box if you have experienced or others have observed in you:

- | | | |
|--|--|---|
| <input type="checkbox"/> change in personality | <input type="checkbox"/> drop things / lose your grip | <input type="checkbox"/> bump into corners |
| <input type="checkbox"/> change in mood/mood swings | <input type="checkbox"/> trip easily | <input type="checkbox"/> neglecting one side |
| <input type="checkbox"/> change in motivation | <input type="checkbox"/> loss of strength | <input type="checkbox"/> confused with left and right |
| <input type="checkbox"/> change in outlook on life | <input type="checkbox"/> difficulty on fine motor skills | <input type="checkbox"/> difficulty with numbers |
| <input type="checkbox"/> change in empathy | <input type="checkbox"/> changes in penmanship | <input type="checkbox"/> blurring of vision |
| <input type="checkbox"/> change in concentration | <input type="checkbox"/> changes with speech | <input type="checkbox"/> double vision |
| <input type="checkbox"/> change in ability to organize | <input type="checkbox"/> changes with your voice | <input type="checkbox"/> blind spots |
| <input type="checkbox"/> feeling of depression | <input type="checkbox"/> difficulty smiling | <input type="checkbox"/> floaters |
| <input type="checkbox"/> irritability | <input type="checkbox"/> strange skin sensations | <input type="checkbox"/> flashes of lights |
| <input type="checkbox"/> extreme fears or phobias | | <input type="checkbox"/> sensitivity to light |
| <input type="checkbox"/> eating disorder | | <input type="checkbox"/> other visual changes |
| <input type="checkbox"/> suicidal thoughts | | |

- memory loss
- difficulty hearing
- difficulty localizing sounds
- poor auditory comprehension
- noise in the ears
- sensitivity to loud noises
- seizures

- tremors of any body part
- twitching/cramping muscles
- stiffness with movement

- changes in coordination
- clumsiness
- unsteadiness when walking in the dark
- chronic joints injury
- moments of unexplained confusion or disorientation

- jaw pain
- grind or clench your teeth
- jaw click / pop
- difficulty chewing
- difficulty opening your mouth
- fatigue easily
- hot flashes
- chills
- cold hands or feet
- sweat easily or excessively
- difficulty with smiling or other facial expression
- change in smell/taste / appetite
- wet or dry eyes
- do you have a drippy nose
- does your nose bleed easily
- difficulty swallowing

- soreness or tightness of throat

- heartburn
- choke easily
- shortness of breath
- coughing or wheezing
- dizziness / light-headedness with change of position
- dizziness / light-headedness with certain positions
- car sickness
- unexplained nausea

- swelling in the legs or feet
- chest pain
- irregular heart beats
- pain legs with walking
- chest pressure
- rapid heart beats
- heart valve problems
- pacemaker

- physical abuse
- sexual abuse
- emotional abuse
 - do not know

- Pain / Numbness / Weakness:
- head / neck
- shoulders /arms / elbows
- wrists / hands / fingers
- upper - mid - low back
- pelvis / tail bone
- hip / groin / thighs
- knees / legs / ankles / feet
- joints
- muscles

- stomach bloating
- digestion problems
- excessive gas
- stomach cramping
- irritable bowel symptoms
- changes in bowel movements
- blood in bowel movements
- persistent / recurrent constipation
- persistent / recurrent diarrhea

- frequent urination
- burning or pain when urinating
- difficulty starting to urinate
- difficulty emptying bladder
- leaking urine
- vaginal dryness
- erectile dysfunction

- weight gain of more than 10lbs in the last 6 months
- weight loss of more than 10lbs in the last 6 months

Skin / Nails / Hair:

- dry
- splitting / cracking
- ridges
- eczema
- acne
- bruise easily
- excess oil
- body odor
- discolored
- unexplained hair loss

THE ABOVE INFORMATION IS ACCURATE AND COMPLETED TO THE BEST OF MY KNOWLEDGE.

signature of patient

date

witness

date

patient's representative name printed

signature of patient's representative

date

In-office review _____