

# LUCAS CHIROPRACTIC

903 Howard St. Walla Walla WA 99362

## 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:

<input type="checkbox"/> NONE For the <b>PRESENTING CONDITION</b> <u>and</u> <b>OTHER CURRENT CONDITIONS</b> which you are treating, please list <b>ALL</b> 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.

<input type="checkbox"/> NO Have you received care from a Chiropractor in the past?		
Who & Where	When & Reason	Outcome

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

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

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

<input type="checkbox"/> <b>NONE</b>	Mother	Father	Sister	Brother	Grand mother	Grand father	Child
<b>Family History</b>							
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 pumber 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 \_\_\_\_\_