

# LUCAS CHIROPRACTIC

903 Howard St. Walla Walla WA 99362

## PATIENT INTAKE - update

Name \_\_\_\_\_ Today's Date \_\_\_ / \_\_\_ / \_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work phone(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-Mail \_\_\_\_\_ **Height** \_\_\_' \_\_\_" **Weight** \_\_\_\_\_ lbs  
**If patient is a minor** name guardian \_\_\_\_\_ relationship \_\_\_\_\_  
**Emergency contact** \_\_\_\_\_ Phone \_\_\_\_\_ 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.

**NONE** Please list any other **serious** 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 <b>H</b>	Outcome

**NONE** prescription or over the counter medications **AND** supplements you are currently taking

Name	Reason	Dosage	Frequency	How long	Side effects

**NONE** Please list all significant trauma (**auto, lifting, fracture, dislocation, sport**)

Type of trauma	Date	Body parts injured	Treatment please if hospitalized write <b>H</b>	Residual problems

