Patient Intake

Today's Date_____/_____/_____

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_____ Date of Birth_____/_____/_____ **SS#**_____-_____-_____
Local address_____City_____State_____Zip_____
Other address_____City_____State_____Zip_____
Gender: M F Height__ __' _ __" **Weight**_____lbs
Please check box for preferred communication means □E-Mail_____
□ Home Phone(_____)_____-_____ □ Work Phone(____)_____-_____□ Cell Phone(____)_____-_____
Ethnicity: □ Hispanic or Latino □ NOT Hispanic or Latino **Race:** □ American Indian or Alaska Native
□ African American or □ Black □ Asian □ Hispanic or Latino □ Hawaiian or Pacific Islander □ White
Preferred language: □ English □ Spanish □_____**If minor patient:** Parent/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

□ **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

□ **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 **<u>H</u>**	**Residual problems**

□ **NONE** **Please list all surgeries or prostheses**			
Surgery if hospitalized please write **<u>H</u>**	**Date**	**Surgeon & location**	**Results**

□ **NONE** **Please list any Allergies**		
Food	**Environmental**	**Medications**

□ **NONE** **Family History**	Mother	Father	Sister	Brother	Grand mother	Grand father	Child
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 (circle one) high - medium – low : major stress factors_____

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

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

□ 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

<u>Pain / Numbness / Weakness:</u>
□ 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

<u>Skin / Nails / Hair:</u>
□ 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_____