Natural Arts
Chiropractic & Acupuncture

PATIENT INTAKE

If applicable, please also fill out the; ***CAR ACCIDENT, WORK COMP, or FERTILITY ADDENDUMS***

PERSONAL INFORMATION

First Name _____ Last Name _____ Date _____

DOB _____ Age_____ Home Phone _____ Cell Phone _____

Email _____ SS# _____

** Email and **LAST 4 of SS#** required for electronic statements, **FULL SS#** required if you have Medicare*

Gender: ☐ M ☐ F If patient is a minor list parent / guardian _____

Appointment text reminders ☐ Yes ☐ No Relationship ☐ Married ☐ Divorced ☐ Other ☐ Separated ☐ Single

Children? ☐ No ☐ Yes (ages if not grown) _____

Home Address _____
Street City State Zip

Emergency Contact _____ Phone _____ Relationship _____

☐ Employed _____ ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled

HOW DID YOU FIND US / GET REFERRED TO US?

☐ Google ☐ Facebook ☐ Family/Friend/Patient _____

☐Health Care Provider (Doctor/Therapist/PT/etc) _____ Other: _____

ACCOUNT INFORMATION

Payment method ☐ No Insurance (Cash/Check/Credit Card) ☐ Insurance ☐ Work Comp ☐ Auto Insurance

☐ CLINIC POLICIES (by checking this box, you agree to our Clinic Policies - **required to be seen**)

For Personal Insurance, if you are **NOT** the **PRIMARY** policy holder, we require that person's info to bill the insurance

Name _____ DOB _____

Choose a billing preference: ☐ Email me my statements (less paper waste :) ☐ Mail me paper statements

ALERTS / NOTES

Do you have **metal implants** in your body? ☐ Yes ☐ No If YES, list _____

_____

IMPORTANT: Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

List any other important information _____

VITALS / SOCIAL

Height _____ Weight _____ Most recent Blood Pressure _____ /_____

Tobacco: ☐ None ☐ Former ☐ 1-2 cigarettes / day ☐ Up to 1 pack / day ☐ More than 1-2 packs / day

Alcohol: ☐ None ☐ Former ☐ 1-2 / day ☐ Light / Social ☐ Binge

Activity: ☐ None ☐ Light ☐ Moderate ☐ Vigorous

Diet: ☐ Poor ☐ Average ☐ Above Avg ☐ Very good ☐ Excellent

Water/Day: ☐ 1-2 cups ☐ 3-4 cups ☐ 5-6 cups ☐ 7-8 cups +

MEDICAL HISTORY

Hospitalizations _____

Surgeries _____

Major injury / trauma_____

Ongoing illness _____

Allergies _____

Medications ☐ *see list* _____

Family History (heart/surgery/illness etc) _____

Previous Tests (X-Ray/MRI/etc) _____

Medical Procedures _____

Nutritional Supplements _____

Past Chiropractic Care _____

General
- ☐ Weakness
- ☐ Recurring fever
- ☐ Recent weight loss or gain
- ☐ Dizziness
- ☐ Fevers
- ☐ Chills
- ☐ Other:

Respiratory
- ☐ Persistent cough
- ☐ Spitting up blood
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Sleep apnea
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Hay fever
- ☐ Other:

Blood / Lymph
- ☐ Anemia
- ☐ Hemophilia / Bleeding
- ☐ Bruising
- ☐ Blood clots
- ☐ Past transfusions
- ☐ Leukemia
- ☐ Lymphoma
- ☐ HIV/ AIDS
- ☐ Sickle cell
- ☐ Other:

Urinary
- ☐ Painful / frequent urination
- ☐ Incontinence
- ☐ Hesitancy
- ☐ Urgency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Genital / bladder complaints
- ☐ Other:

Female
- ☐ Painful sex
- ☐ Vaginal discharge
- ☐ Breast pain or lumps
- ☐ Hot flashes
- ☐ Menstrual irregularity
- ☐ Loss of libido
- ☐ Menopause
- ☐ STD

HEENT
- ☐ Headaches / Migraines
- ☐ Eye or vision problems
- ☐ Eyeglasses or contacts
- ☐ Nose bleeds
- ☐ Eye surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Nose congestion / sinuses
- ☐ Ear or hearing problems
- ☐ Dental problems
- ☐ Gum problems
- ☐ TMJ
- ☐ Post nasal drip
- ☐ Others:

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Stomach ulcer
- ☐ Bloating / cramping
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Change in bowel habits
- ☐ Black or bloody stools
- ☐ Colon cancer / colon polyps
- ☐ Food sensitivities
- ☐ IBS
- ☐ Crohn's
- ☐ Gastric reflux
- ☐ Colitis
- ☐ Other:

Allergies
- ☐ Seasonal
- ☐ Food
- ☐ Medicine
- ☐ Others:

Skin / Hair
- ☐ Skin trouble or rashes
- ☐ Flushing
- ☐ Excessive acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Skin pigmentation issues
- ☐ Change in hair or nails
- ☐ Blood in stools
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ Other:

Neurological
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory loss
- ☐ Poor balance
- ☐ Fainting spells
- ☐ Numbness or tingling
- ☐ Pins and needles
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Head injury
- ☐ Anxiety or panic
- ☐ Depression
- ☐ Sleeping issues
- ☐ Weak muscles
- ☐ Loss of smell or taste
- ☐ Temporary loss of vision
- ☐ Difficulty concentrating
- ☐ Other:

Psychiatric
- ☐ Alzheimer's
- ☐ Insomnia
- ☐ Difficulty concentrating
- ☐ Memory loss / confusion
- ☐ Depression
- ☐ Anxiety
- ☐ Agitation / irritability
- ☐ Suicidal thoughts
- ☐ Chemical dependency
- ☐ Sex abuse victim
- ☐ Other:

Cardiovascular
- ☐ Chest pain or tightness
- ☐ Heart attack
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling of feet or hands
- ☐ High blood pressure
- ☐ High cholesterol / trigcly.
- ☐ Heart murmur
- ☐ Blood clots
- ☐ Pacemaker
- ☐ Mitral valve prolapse
- ☐ Congenital heart defects
- ☐ Rheumatic fever
- ☐ Leg pain upon walking
- ☐ Varicose veins
- ☐ Dizziness
- ☐ Excessive bruising
- ☐ Coronary artery disease
- ☐ Other:

Musculoskeletal
- ☐ Arthritis
- ☐ Joint pain or swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Trauma
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Cramping
- ☐ Fractures
- ☐ Implants, plates, screws
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot / ankle pain
- ☐ Shoulder problems
- ☐ Elbow / wrist pain
- ☐ Gout
- ☐ Disc bulge / herniation
- ☐ Other:

Endocrine
- ☐ Diabetes
- ☐ Excessive sweating
- ☐ Heat intolerant
- ☐ Cold intolerant
- ☐ Weight loss
- ☐ Weight gain
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Hair changes
- ☐ Hyperthyroidism
- ☐ Cushing's syndrome
- ☐ Other

** <u>if you are here for fertility only, skip this page</u> **

COMPLAINTS

Describe IN DETAIL why you're here (pain, headaches, injury, etc) and how/when it began:

Grade your complaints 0-10 with 0 = nothing and 10 = the worst

DAILY LIFE THINGS this has interfered with: (work / home duties / exercise / sleep / everything / etc)

TREATMENTS & TESTS you have done: (MD / PT / Chiropractor / Massage / X-Ray - MRI / Ortho / None)

What makes this **BETTER?** (rest / ice / meds / chiro / massage / acupuncture / exercise / nothing)

What makes this **WORSE?** (activity-working / walk / stand / sit / bend / turn / twist / lifting / nothing)