

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 _____

Gender: M F Email _____

If patient is a minor list parent / guardian _____

Preferred communication: Phone Email Do you want appointment text reminders? Yes No

SS # _____ Marital: Divorced Married Other Separated Single Widow

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 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

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

Name _____

DOB _____

ALERTS / NOTES

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

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 problems
- Other:

Female

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

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
- Other:

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 / triglyc.
- 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

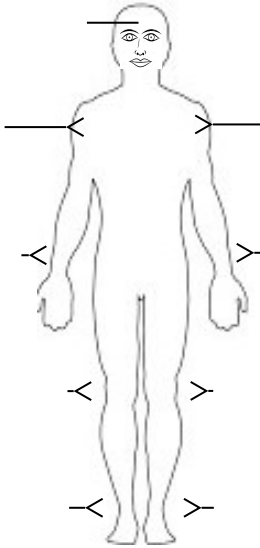
- Diabetes
- Excessive sweating
- Heat intolerant
- Cold intolerant
- Weight loss
- Weight gain
- Frequent urination
- Excessive thirst
- Hair changes
- Hyperthyroidism
- Cushing's syndrome
- Other

**** if you are here for fertility only, skip this page ****

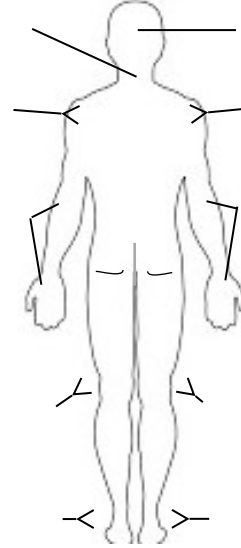
COMPLAINTS

Grade the general areas where you have problems 1-10 (1 = mild, 10 = severe)

FRONT



BACK



Describe your problems in detail (achy, tight, burning, numb, sharp, etc) & explain how they started

What daily activities are affected: Working Household School / Sports Sleeping All

Other:

Treatments/Tests done so far: MD PT Massage Chiropractic XRay/MRI None

Other:

What makes this better? Rest Activity Treatment Medications Ice/Heat None

Other:

What makes this worse? Activity Lifting Working School/Sports Sit/Stand All

Other: