Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form.*** Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Date: ____ **SSN:** ____ **DOB:** ____ **Age:** ____

First Name: ____ **Middle Initial:** ____ **Called Name:** ____ **Last Name:** ____

Sex: ◯M ◯F **Race:** ____ **Ethnicity:** ____ **Height:** ____ **Weight:** ____

Marital Status: ◯S ◯M ◯W ◯D ◯Sep **Spouse Name:** ____ **# Of Children:** ____

Home #: ____ **Cell #:** ____ **Work #:** ____

Address: ____

City: ____ **State:** ____ **Zip:** ____ **Email:** ____

Emergency Contact: ____ **Emergency Relation:** ____ **Emergency Phone:** ____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed **Employer Name:** ____

Employer Address: ____ **City:** ____ **State:** ____ **Zip:** ____

Complaint Information

Injury Occurred: ◯Automobile ◯Work ◯Third-Party ◯Other **Injury Date:** ____

Injury Origin: ____

Describe Discomfort: ____

Frequency: ◯Always ◯Hourly ◯Daily ◯Occasionally

Interfere w/ Activities: ◯Yes ◯No **Affected Sleep:** ◯Yes ◯No

Missed Work: ◯Yes ◯No **Unable to Work from:** ____ **Unable to Work til:** ____

Affected Appetite: ◯Yes ◯No Explain: ____

Reduced Work: ◯Yes ◯No Explain: ____

Does it Worsen: ◯Yes ◯No Explain: ____

Weather Affects it: ◯Yes ◯No Explain: ____

Aggravates Condition: ____

Improves Condition: ____

Received Treatment: ◯Yes ◯No Explain: ____

X-rays Taken: ◯Yes ◯No Explain: ____

Same Condition Before: ◯Yes ◯No **Date:** ____ **Practitioner:** ____

Chiropractic Experience

Who referred you to our office? ____

How did you find our office? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing

Have you been adjusted by a chiropractor before? ◯Yes ◯No

If yes, what was the reason? ____

Doctor's Name: ____ **Date of last visit:** ____

Social History & Life Choices

Alcohol: ◯Daily ◯Weekly ◯Occasionally ◯Never **Caffeine Drinks:** ◯Daily ◯Weekly ◯Occasionally ◯Never

Soft Drinks: ◯Daily ◯Weekly ◯Occasionally ◯Never **Exercise:** ◯Daily ◯Weekly ◯Occasionally ◯Never

Water: ◯Daily ◯Weekly ◯Occasionally ◯Never **Tobacco:** ◯Daily ◯Occasionally ◯Past ◯Never

History

List current Medications: ____________________

(name, length of use, reason for use)

List current vitamins, minerals, supplements, or herbs: ____________________

(name, length of use, reason for use)

Have you ever:

Broken Bones: ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No Explain: ____________________

Sprains/Strains: ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No Explain: ____________________

Hospitalized: ◯ Yes ◯ No Explain: ____________________

Surgery: ◯ Yes ◯ No Explain: ____________________

Auto Accident: ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No Explain: ____________________

Struck Unconscious: ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No Explain: ____________________

Eating Disorder: ◯ Yes ◯ No Explain: ____________________

Stroke: ◯ Yes ◯ No Explain: ____________________

Family Health History: ____________________

Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.

Last Physical Exam: __________ **Primary Phys:** __________ **Phys Phone #:** __________

Health Conditions: ____________________

Health Checklist

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

☐ Allergies	☐ Alcoholism	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis
☐ Asthma	☐ Back Pain	☐ Breast Lump	☐ Bronchitis	☐ Bruise Easily
☐ Cancer	☐ Chest Pain	☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems	☐ Dizziness	☐ Excessive Menstruation
☐ Eye Pain or Difficulties	☐ Fatigue	☐ Frequent Urination	☐ Headache	☐ Hemorrhoids
☐ High Blood Pressure	☐ Hot Flashes	☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance	☐ Loss of Smell	☐ Loss of Taste
☐ Nosebleeds	☐ Pacemaker	☐ Polio	☐ Poor Posture	☐ Prostate Trouble
☐ Sciatica	☐ Shortness of Breath	☐ Spinal Curvatures	☐ Sinus Infection	☐ Insomnia
☐ Swollen Joints	☐ Stroke	☐ Swelling of Ankles	☐ Ulcers	☐ Thyroid Condition
☐ Tuberculosis	☐ Varicose Veins	☐ Venereal Disease	☐ Other: __________	

Women Only

Are you pregnant? ◯ Yes ◯ No **Are you taking birth control?** ◯ Yes ◯ No **Do you have irregular cycles?** ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No **Do you experience painful periods?** ◯ Yes ◯ No **Do you have breast implants?** ◯ Yes ◯ No

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh you needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **I want the Doctor to select the type of care appropriate for my condition.**

☐ **Relief Care:** Symptomatic relief of pain or discomfort.

☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

Authorization

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ____________________ Date: __________ Print parent name if under 18: ____________________

☐ Adult Patient ☐ Parent of Guardian ☐ Spouse