

# INTAKE FORM

## PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Would you like your appointment reminder to be by text message? Y N

SSN (optional): \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_

Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Employer: \_\_\_\_\_

Who may we thank for your Referral?  \_\_\_\_\_

Yellow Pages  Mail  Clinic Location.  Other \_\_\_\_\_

Payment for Services will be by:  Self Pay, (Cash, Check or Debit/Credit Card)

Medical Insurance  Automobile Insurance  Worker's Compensation

## PAST MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**

(Please indicate which **PAST conditions** have been experienced **prior to present complaint** by marking appropriate boxes located to the left of the conditions listed). Leave blank if N/A

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vd

Have you been treated by a physician for any health condition in the last year?  Yes  No

Describe Condition \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

### SURGICAL HISTORY:

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had a metal implant?  Yes  No Ever been gunshot?  Yes  No

ACCIDENT HISTORY:  Job  Auto  Other 1. \_\_\_\_\_ Date: \_\_\_\_\_

Job  Auto  Other 2. \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

*Please Rate Your Symptoms using a 1-10 pain scale (with 1 being little to no pain)*

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Who has provided most recent Chiropractic care? \_\_\_\_\_

When was your last Chiropractic appointment? \_\_\_\_\_

Answer all of the following that apply with regard to your most serious complaint from above:

SYMPTOMS ARE WORSE IN  MORNING  AFTERNOON  NIGHT

WHEN AND HOW OCCURRED? \_\_\_\_\_

SYMPTOMS DEVELOPED FROM:  JOB RELATED INJURY  AUTO ACCIDENT  OTHER  
 ACCIDENT  ILLNESS  UNKNOWN CAUSE  GRADUAL ONSET

DATE OCCURRED: \_\_\_\_\_

SYMPTOMS HAVE PERSISTED FOR # \_\_ HOUR(S) \_\_ DAY(S) \_\_ WEEK(S) \_\_ MONTH(S) \_\_ YEAR(S)

SYMPTOMS/COMPLAINTS:  COME & GO  ARE CONSTANT

What is your Primary Goal or Expectation with Care?

\_\_\_\_\_

HAVE YOU EVER HAD THIS BEFORE:  NO  YES WHEN? \_\_\_\_\_

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

\_\_\_\_\_

ARE YOU PREGNANT  NO  YES DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**

BENDING  REACHING  STRAINING AT STOOL  COUGHING  SITTING  TURNING  
HEAD  LIFTING  SNEEZING  WALKING  LYING DOWN  STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**

BENDING  SITTING  LIFTING  STANDING  LYING DOWN  TURNING HEAD  
 REACHING  WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

blurred vision  buzzing in ears  cold feet  cold hands  cold sweats  concentration loss  
/confusion  constipation  depression/weeping spells  diarrhea  dizziness  face flushed  
 fainting  fatigue  fever  head seems too heavy  headaches  insomnia  light bothers eyes  
 loss of balance  loss of smell  loss of taste  low resistance to colds  muscle jerking  
 numbness in fingers  numbness in toes  pins and needles in arms  pins and needles in legs  
 ringing in ears  shortness of breath  stiff neck  stomach upset

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_