PATIENT INTAKE FORM

TODAY'S DATE: ____________

LAST NAME: ____________ FIRST NAME: ____________

HOW WOULD YOU LIKE TO BE ADDRESSED? ____________

DATE OF BIRTH: ____________ AGE: ____________ GENDER: ________ SSN: ____________

YOUR ADDRESS: ____________ CITY: ________ STATE: ______ ZIP CODE: ________

HOME PHONE: ____________ CELL PHONE: ____________ EMAIL: ____________

YOUR OCCUPATION: ____________ WORK PHONE: ____________

EMPLOYER: ____________

MARITAL STATUS (CIRCLE ONE): SINGLE/MARRIED/DIVORCED/SEPARATED/WIDOWED

SPOUSE'S NAME: ____________ OCCUPATION: ____________

DATE OF BIRTH: ____________ WORK PHONE: ____________

EMPLOYER: ____________

WAS THIS RELATED TO: ❑ AUTO ACCIDENT ❑ WORK INJURY ❑ OTHER

Is this patient covered by insurance? ❑ Y ❑ N If no, how will you pay for this visit? ________

Primary Insurance Information:

Subscriber Name: ____________

Subscriber Birthdate: ____________ Subscriber SS#: ____________

Subscriber Address: ____________

Home Phone #: ____________ Is this person a patient here? ❑ Y ❑ N

Subscriber Employer: ____________ Primary Insurance Carrier: ____________

ID#: ____________ Group #: ____________

Patient's Relation to the Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance Information:

Subscriber Name: ____________

Subscriber Birthdate: ____________ Subscriber SS#: ____________

Subscriber Address: ____________

Home Phone #: ____________ Is this person a patient here? ❑ Y ❑ N

Subscriber Employer: ____________ Primary Insurance Carrier ____________

ID#: ____________ Group #: ____________

Patient's Relation to the Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

FOR DOCTOR'S USE ONLY

DR. REVIEWED	SYSTEMS	SYMPTOMS
_____	GENERAL	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
_____	HEAD	Trauma, headaches, dizziness, light headedness
_____	NECK	Stiffness, lumps/swelling/masses, pain
_____	CARDIAC	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____	MUSCULOSKELETAL	Bone/joint pain, swelling, joint deformity, trauma, restricted range of motion weakness, atrophy
_____	NEUROLOGICAL	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia

❑ ADDENDUM

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? ____________ HOBBY? ____________

DO YOU SMOKE? ❑ YES ❑ NO HOW MUCH? ____________

DO YOU EXCERISE? ❑ YES ❑ NO HOW OFTEN? ____________ TYPE: ____________

DOCTOR'S NOTES:

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING?

Y N	BROKEN/FRACTURED BONES	Y N	OSTEOARTHRITIS	Y N	GALL BLADDER
Y N	CIRCULATORY PROBLEMS	Y N	EPILEPSY	Y N	TUMORS
Y N	RHEUMATOID ARTHRITIS	Y N	PACEMAKER	Y N	DIABETES
Y N	HIGH/LOW BLOOD PRESSURE	Y N	A CONGENITAL DISEASE	Y N	CANCER
Y N	EXCESSIVE BLEEDING	Y N	DEPRESSION	Y N	STROKES
Y N	SEIZURES/CONVULSION	Y N	COUGHING BLOOD		

WHEN WAS YOUR LAST PHYSICAL EXAM? ____________

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND?

❑ DAYS ❑ WEEKS ❑ MONTHS ❑ YEARS

DRUG RELATED ALLERGIES: ____________

IDENTIFY ANY DOCTORS YOU ARE CURRENTLY SEEING FOR ANY OF THESE CONADIDTIONS AND ANY TREATMENT YOU RECEIVED

1. ____________
2. ____________
3. ____________

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

1. ____________
2. ____________
3. ____________
4. ____________
5.

PATIENT: ______________________________ DATE: __________________________

PATIENT HISTORY

1. What is your **main complaint?** ________________________________
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

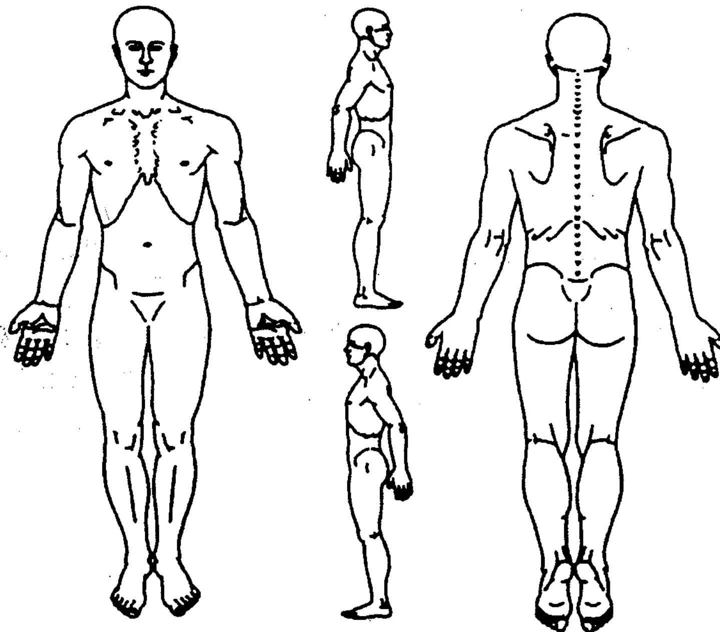
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

		Occasional			*Intermittent*		*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** ________
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature:________________

Date: ____/____/____

6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? ______________________________
8. What makes it feel worse? ______________________________
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?____________ to ____________
12. Are you Pregnant? ❑ Yes ❑ No Date Due __________
13. What was the first day of your last menstrual cycle? ___________
14. Number of pregnancies? _______ Miscarriages? ___________