**Patient Intake Form**

Patient Name: Click here to enter name. Age: Click here to enter age. Birth Date: Date.

 Address: Street. ,City. Choose a State. Zip.

Primary Phone: Primary. Type: Choose an item.

Secondary Phone: Secondary. Type: Choose an item.

Would you like to receive appointment reminders? [ ]  Yes [ ]  No Please select a Wireless Carrier.

 Email address: Email.

Occupation: Occupation. Employer: Employer.

Previous Chiropractor: Chiropractor’s Name. [ ] N/A Last adjustment: Click here to enter a date.

How did you hear about us? Connection.

Marital Status: Choose an item. How many children: Number of children. Ages: Their ages.

Would you like this office to verify your health insurance coverage? [ ]  Yes [ ]  No

Insurance Coverage: Choose an item.

**EMERGENCY CONTACT INFORMATION**

Emergency Contact Person: Contact. Phone: Phone Number. Relationship: Relationship.

**What is your primary complaint?** Click here to enter complaint.

If yes, when did this complaint begin? Date.

How did it begin? Accident, Slept funny, unsure, etc.

What makes it better? Icing, Rest, Stretching, etc. What makes it worse? Icing, Rest, Stretching, etc.

Since the onset, has the complaint? [ ]  Improved [ ]  Worsened [ ]  About the same [ ]  N/A [ ]  Uncertain

If you are currently experiencing pain

(mark all that apply)

[ ] Sharp [ ] Dull ache [ ]  Burning [ ]  Throbbing [ ]  Stabbing [ ]  Shooting [ ]  Numbness [ ]  Tingling

Does the pain: [ ]  Come & Go [ ]  Constant

How would you rate your pain? Choose an item.

0=no pain, 10=worst possible pain

How often does this pain occur?

[ ]  Hourly [ ]  Daily [ ]  Weekly [ ]  Occasionally

How many hours a day do you spend sitting: Number of Hours. hrs

If the pain travels, where does it go?

Location.

Is this keeping you from

[ ]  Working [ ]  Exercising [ ]  Sports/hobbies

[ ]  Driving [ ]  Sleeping [ ]  Quality Family Time

How would you rate your HEALTH RIGHT NOW? Choose an item. 0=Unhealthy, 10=Optimum Health

**Would you like to be:** [ ]  **HEALTHY** [ ]  **Pain FREE** [ ]  **NOT sick**

 \*Women Only: Are you pregnant or is there any possibility you may be pregnant? [ ]  Yes [ ]  No [ ]  Uncertain

Below is a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Mark the following conditions that are currently a cause of significant concern. Please mark **S for Self or F for family member**.

**Current Significant Musculo – Skeletal concerns**

[ ] S [ ] F Back/Neck Pain

[ ] S [ ] F Leg Pain/Sciatica

[ ] S [ ] F Carpel Tunnel

[ ] S [ ] F Headaches

[ ] S [ ] F Scoliosis

[ ] S [ ] F Arthritis

[ ] S [ ] F Joint pain

[ ] S [ ] F Swollen joint(s)

**Current Significant Cardiovascular concerns**

[ ] S [ ] F Chest Pain/Angina

[ ] S [ ] F Myocardial Infarction

[ ] S [ ] F Cold Extremities

[ ] S [ ] F Heart Problems

☐S ☐F Blood pressure Problems

[ ] S [ ] F Arterio/Athero sclerosis

[ ] S [ ] F Anemia

[ ] S [ ] F Varicose Veins

[ ] S [ ] F Stroke

**Current Significant Gastrointestinal concerns**

[ ] S [ ] F Abnormal Appetite

[ ] S [ ] F Increased Thirst

[ ] S [ ] F Ulcers

[ ] S [ ] F Nausea

☐S ☐F Vomiting

[ ] S [ ] F Diarrhea

[ ] S [ ] F Constipation

[ ] S [ ] F Bloating/Gas

[ ] S [ ] F GERD/Acid Reflux

[ ] S [ ] F Bad Breath

[ ] S [ ] F Heartburn

[ ] S [ ] F Gall Stones

**Current Significant Urinary/Reproductive concerns**

[ ] S [ ] F Kidney Infection

[ ] S [ ] F Kidney Stones

[ ] S [ ] F Frequent Urination

[ ] S [ ] F Painful Urination

[ ] S [ ] F Discolored Urination

[ ] S [ ] F Bladder Trouble

[ ] S [ ] F Impotence

[ ] S [ ] F Prostate Problems

[ ] S [ ] F Decreased Sex Drive

[ ] S [ ] F Hemorrhoids

[ ] S [ ] F Fibroids

[ ] S [ ] F Cysts

[ ] S [ ] F Excessive Menstruation

[ ] S [ ] F Painful Menstruation

[ ] S [ ] F Endometriosis

[ ] S [ ] F Hot Flashes

[ ] S [ ] F Cramps

[ ] S [ ] F PMS

[ ] S [ ] F STD’s

[ ] S [ ] F Pregnant

**Current Significant Nervous System concerns**

[ ] S [ ] F Nervousness

[ ] S [ ] F Anxiety

[ ] S [ ] F Numbness/Tingling

[ ] S [ ] F Shooting Pain

[ ] S [ ] F Paralysis

[ ] S [ ] F Forgetfulness

[ ] S [ ] F Seizures

[ ] S [ ] F Loss of Balance

[ ] S [ ] F Loss of Smell

[ ] S [ ] F Dizziness/Vertigo

[ ] S [ ] F Loss of Taste

**Current Significant General concerns**

[ ] S [ ] F Allergies

[ ] S [ ] F Fatigue

[ ] S [ ] F Insomnia

[ ] S [ ] F Depression

[ ] S [ ] F ADD/ADHD

[ ] S [ ] F Colic

[ ] S [ ] F Lung Problems

[ ] S [ ] F Cancer

[ ] S [ ] F Diabetes

[ ] S [ ] F Autism

[ ] S [ ] F Heart Disease

[ ] S [ ] F Chicken Pox

[ ] S [ ] F Herpes Zoster/Simplex

[ ] S [ ] F Hearing

[ ] S [ ] F Dental

[ ] S [ ] F Vision

List medications you are currently taking (including over-the-counter, supplement and herbs). List medications.

List any accidents or traumas, when they happened, and what was injured. List of incidents.

Please list any major surgeries and date: Surgeries. Click here to enter a date.

Name of Primary Care Physician Dr.’s Name. Date of last visit: Click here to enter a date.

Have you been treated for any conditions in the past year? [ ]  No [ ]  Yes: If YES, please explain.

Please include any additional information, concerns or questions would like to add. Anything else?

[ ] *The statements made as to the questions asked on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation.* • *I understand that any and all information on this form and in the file will remain confidential to myself, the doctor, and any other authorized personnel.* • *I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.* • *I acknowledge and approve for my electronic signature to be considered the same as my written signature.*

**Signature: Click here to acknowledge and sign form. Date: Click here to enter the date.**