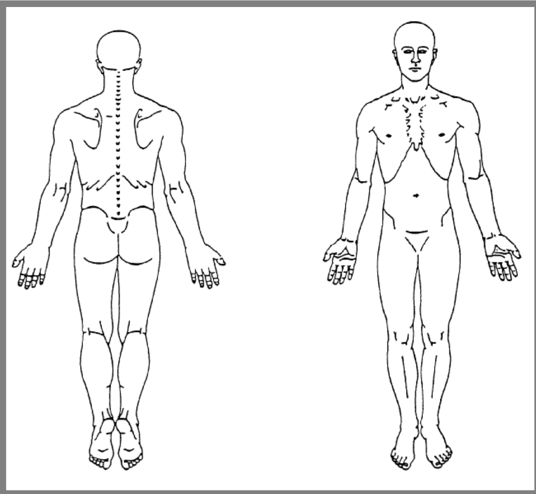
Patient Intake Form

LIGHTHOUSE CHIROPRACTIC

Patient name:_______________________________________ Age: _______ Birth Date:_____/_____/_____
Address:______________________________ City:______________ State:_______ Zip Code:________________
Home phone:____________________ Work phone:____________________ Cell phone:_____________________
Email address:______________________________________
Occupation:_______________________________Employer:____
How did you hear about us?____
Marital Status: S M W D How many children: _______ Ages: _________________________________
Would you like this office to verify your health insurance coverage? ______________________________
Insurance Coverage: ___ Medicare ___ Auto Accident ___ Worker's Comp ___ Major Medical ___ Other

EMERGENCY CONTACT INFORMATION
Emergency Contact Person:____
Phone#:______________________________Relationship:_______________________________________

Do you have a primary complaint?____
When did this complaint begin?____________________________________How did it begin?_______________
What makes it better?____
What makes it worse?____



Please mark on the diagram where your pain is occurring.

If you are currently experiencing pain, is it:
(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?
0=no pain, 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How often does this pain occur? __*Hourly* __*Daily* __*Weekly* __*Occasionally* __*N/A*

If the pain travels, where does it go? ____

Since the onset, has the complaint? __*Improved* __*Worsened* __*About the same* __*N/A* __*not sure*

Is this keeping you from …

__*Working* __*Exercising* __*Sports/hobbies* __*Driving* __*Sleeping* __*Quality Family Time*

How would you rate your **HEALTH** RIGHT NOW? ***0 1 2 3 4 5 6 7 8 9 10***

0=Unhealthy, 10=Optimum Health

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

*<u>Women Only</u>: Are you pregnant or is there any possibility you may be pregnant? Yes___ No___ Uncertain___

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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

- ○ Back/Neck Pain
- ○ Leg Pain/Sciatica
- ○ Carpel Tunnel
- ○ Headaches
- ○ Scoliosis
- ○ Arthritis
- ○ Joint pain
- ○ Swollen joint

Current Significant **Cardiovascular** concerns

- ○ Chest Pain/Angina
- ○ Cold Extremities
- ○ Heart Problems
- ○ Blood pressure Problems
- ○ Arterio/Athero sclerosis
- ○ Anemia
- ○ Varicose Veins
- ○ Stroke

Current Significant **Gastrointestinal** concerns

- ○ Abnormal Appetite
- ○ Increased Thirst
- ○ Ulcers
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Bloating/Gas
- ○ GERD/Acid Reflux
- ○ Bad Breath
- ○ Heartburn
- ○ Gall Stones

Current Significant **Urinary**/**Reproductive** concerns

- ○ Kidney Infection
- ○ Kidney Stones
- ○ Frequent Urination
- ○ Painful Urination
- ○ Discolored Urination
- ○ Bladder Trouble
- ○ Impotence
- ○ Prostate Problems
- ○ Decreased Sex Drive
- ○ Hemorrhoids
- ○ Fibroids
- ○ Cysts
- ○ Excessive Menstruation
- ○ Painful Menstruation
- ○ Endometriosis
- ○ Hot Flashes
- ○ Cramps
- ○ PMS
- ○ STD's
- ○ Pregnant

Current Significant **Nervous System** concerns

- ○ Nervousness
- ○ Anxiety
- ○ Numbness/Tingling
- ○ Shooting Pain/
- ○ Paralysis
- ○ Forgetfulness
- ○ Seizures
- ○ Loss of Balance
- ○ Loss of Smell
- ○ Dizziness/Vertigo
- ○ Loss of Taste

Current Significant **General** concerns

- ○ Allergies
- ○ Fatigue
- ○ Insomnia
- ○ Depression
- ○ ADD/ADHD
- ○ Colic
- ○ Lung Problems
- ○ Cancer
- ○ Diabetes
- ○ Autism
- ○ Heart Disease
- ○ Chicken Pox
- ○ Herpes Zoster/Simplex
- ○ Hearing
- ○ Dental
- ○ Vision

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

____
____
____
____
____
____

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

____
____
____
____
____
____

Please list any major surgeries:____Date:______________

____Date:______________

Name of Primary Care Physician and Approx. Date of last visit:________________________________

Have you been treated for any conditions in the past year? __Yes __No

If yes, please explain:____

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

____

____

For recorded keeping purposes, if you have not been seen for an adjustment within a six-month period, we will consider your file closed.

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.

Signature:____ Date:____________________