

## New Patient Intake Form

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Other Children: Yes No

Ages: \_\_\_\_\_

Employment Status:  Employed  Unemployed  FT Student  PT Student  Other \_\_\_\_\_

### Emergency Contact

Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Contact Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Would you like us to verify your health insurance coverage? Yes No

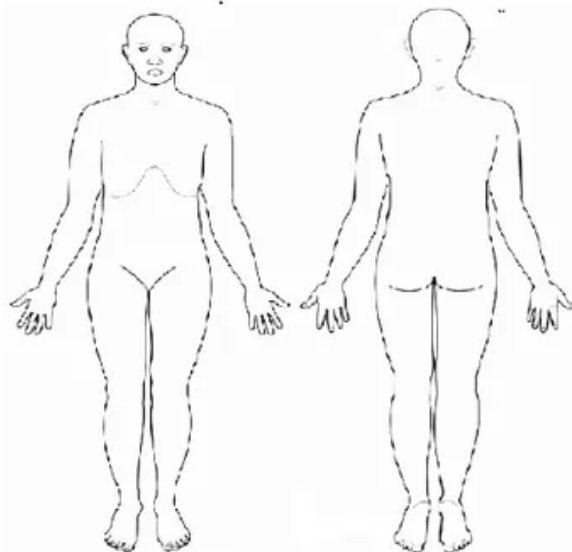
How did you hear about our office? \_\_\_\_\_

Do you have a primary complaint? \_\_\_\_\_

When and how did it begin? \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

(\*Women Only) Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain \_\_\_\_\_



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 and go \_\_\_\_\_ Constant \_\_\_\_\_

How often does the pain occur? Hourly \_\_\_\_\_

Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Occasionally \_\_\_\_\_ N/A \_\_\_\_\_

If the pain travels, where does it

go? \_\_\_\_\_

How would you rate your pain? (0 = no pain, 10 = worst pain possible): 0 1 2 3 4 5 6 7 8 9 10

Since the onset, has the complaint? Improved \_\_\_\_\_

Worsened \_\_\_\_\_ Stayed the same \_\_\_\_\_ N/A \_\_\_\_\_

Is this keeping you from...

Working \_\_\_\_\_ Exercising \_\_\_\_\_ Sports/hobbies \_\_\_\_\_ Driving \_\_\_\_\_ Sleeping \_\_\_\_\_ Family Time \_\_\_\_\_

How would you rate your HEALTH right now? (0 = Unhealthy, 10 = Optimum Health)

0 1 2 3 4 5 6 7 8 9 10

Have you ever been under chiropractic care? If so, when?

Following, 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.

**Current Significant MUSCULOSKELETAL concerns:**

Back/Neck Pain\_\_\_\_ Carpal Tunnel\_\_\_\_ Scoliosis\_\_\_\_ Joint Pain\_\_\_\_  
Leg Pain/Sciatica\_\_\_\_ Headaches\_\_\_\_ Arthritis\_\_\_\_ Swollen Join\_\_\_\_

**Current Significant CARDIOVASCULAR concerns:**

Chest Pain/Angina\_\_\_\_ Blood Pressure Issues\_\_\_\_ Anemia\_\_\_\_ Cold Extremities\_\_\_\_  
Varicose Veins\_\_\_\_ Heart Problems\_\_\_\_ Arterio/Athero Sclerosis\_\_\_\_ Stroke\_\_\_\_

**Current Significant GASTRO-INTESTINAL concerns:**

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

**Current Significant URINARY/REPRODCUTIVE concerns:**

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

**Current Significant NERVOUS SYSTEM concerns:**

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

**Current Significant GENERAL concerns:**

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

**List All Current Medications (include all over-the-counter, supplements, and herbs):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List any accidents or traumas, when they happened, and what was injured:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List any major surgeries:**

Name of Primary Care Physician and Approx. Date of Last Visit: \_\_\_\_\_

Have you been treated for any conditions in the last year? Yes No

If yes, please explain: \_\_\_\_\_

Please include any additional information, concerns, or questions you would like to add: \_\_\_\_\_

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** \_\_\_\_\_