

Patient Intake Form

For Office Use Only
Date: _____
Acct #: _____

Name: _____ Social Security# _____
Address: _____ City _____ State _____ Zip _____
E-Mail address: _____ Age _____ D.O.B. _____ Race _____ Sex: Male/ Female
Marital: M S W D Cell Phone: _____ Home Phone: _____
Employer _____ Occupation _____ Office Phone _____
Name of Emergency Contact _____ Address _____ Phone _____
Family Medical Doctor _____
Referred By: _____

Are your present problems due to an injury? Yes No Enter the date of the injury: _____
Was the injury? Job Related Auto Accident Personal Injury Other: _____
Has the accident been reported? Yes No If so, to whom? To Employer Auto Carrier Other: _____
Briefly describe the accident, injury or illness: _____

List any tests, studies or medications received for this condition:

Tests/Studies: _____
 Medications: _____

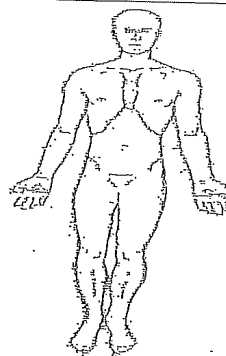
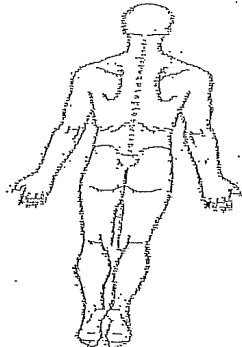
Where you admitted to the hospital due to this condition: Yes No

If yes, what hospital? _____ Transported by? Ambulance Police Other: _____

Date Admitted: _____ Date Released: _____ Length of Stay: _____

List the hospital procedures received: _____

List symptoms you are experiencing today: _____ Choose the severity level associated with each symptom
_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe



When, or approximately when did the complaint start? _____

Is your condition Constant Intermittent (occurs on and off)?

What makes your pain decrease? _____

What makes your pain increase? _____

Has there been any changes in your bodily functions? Urination Defecation Vision Respiration Digestion Other: _____

Does your condition affect your daily activities? Yes No If yes please explain:

What type of work do you do? _____

Do you have any current work restrictions due to this condition?

Off work: Yes No Previously From: _____ To: _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

What type of work do you do? _____

Do you suffer from any condition other than that for which you are now consulting us? Yes No _____

List any past conditions you may have had: _____

Habits		EXERCISE	FAMILY HISTORY			
<input type="checkbox"/> Smoker	Packs per day: _____	None	Diabetes	Cancer	Back Pain	Other
<input type="checkbox"/> Drinking	Alcohol cups/ day	Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coffee	Cups/Day: _____	Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Soft Drink	Bottles or Cans/Day: _____	Type: _____	Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Water	Cups/Day: _____					

Are you taking any medication (prescription or over-the-counter)? Yes No

If Yes, which ones? _____

Have you taken any medications in the past? Yes No If yes, which ones?: _____

Do you have allergies to medication? Yes No

If Yes, please list: _____

Have you ever had any surgeries? Yes No (If yes, please enter the approximate date of surgery.)

DATE	DATE	DATE
_____ Back Operation	_____ Hernia	_____ Gall Bladder
_____ Female Organs	_____ Thyroid	_____ Stomach
Other _____		

Do you have a Pacemaker? Yes No

Any Unexplained weight loss (more than 10 lbs) Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	RESPIRATORY
<input type="checkbox"/> Allergy(What) _____ _____	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Deafness	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chills (Constant)	<input type="checkbox"/> Constipation	<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> Fainting	<input type="checkbox"/> Hemorrhoids (piles)	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Frequent Colds	GENTO-URINARY
<input type="checkbox"/> Headache	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Numbness or Pain in arms/legs/hands	<input type="checkbox"/> Heart Burn	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Prostate Trouble
	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Tonsillitis	
MUSCLES & JOINTS	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR FEMALES ONLY
<input type="checkbox"/> Backache	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Cramps
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Dryness	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Hernia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Eczema	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Hives or Allergy	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Itching	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Rapid Heart	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Pregnant Now?
<input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> Slow Heart	<input type="checkbox"/> Skin Eruptions	_____ Last Pap Date
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Strokes		_____ Last Menstrual Cycle
<input type="checkbox"/> Tremors	<input type="checkbox"/> Swelling Ankles		
	<input type="checkbox"/> Varicose Veins		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | | | |
|---------------------------------------|--------------------------------------|--|------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV Positive |
-
-

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____