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:_____

_____

Have you had difficulty sleeping since the accident? ❑Yes ❑No
List any tests, studies or medications received for this condition:
❑Tests/Studies: _____
❑Medications: _____
Did you see any other doctors for this condition? ☐Yes ☐No Name of Doctor : _____

STRESS LEVELS:
How would you rate your stress level? ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
Explain:_____
Where in your body do you hold or carry your stress? _____
Do you suffer from anxiety? ☐Yes ☐No
Do you have insomnia? ☐Yes ☐No

Original

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
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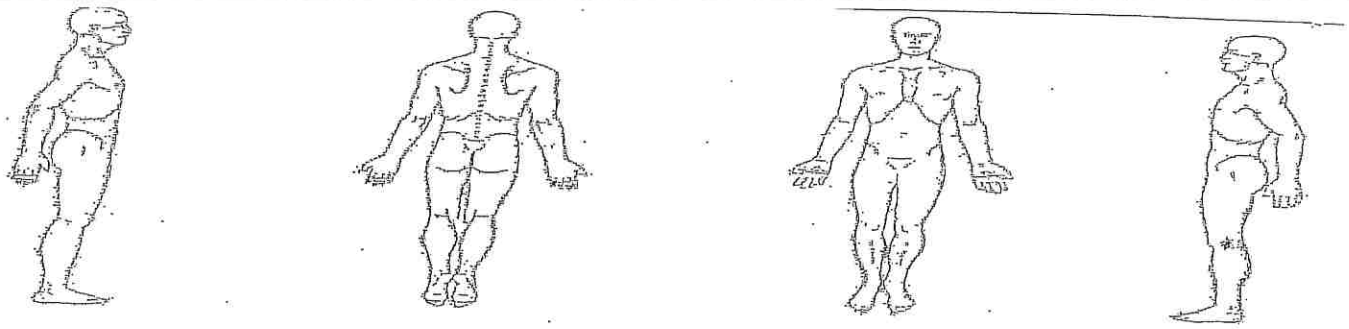
Please mark area(s) of complaint below:



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?) _____

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?: _____

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 any **X-rays/MRI/CT** or any other images done in the areas in which you are consulting us for? ❑Yes ❑No

When/Where? _____

Are there any other health issues you would like for like for us to be aware of? (ex. Multiple Sclerosis, Heart Arrythmia, Rheumatoid Arthistis,etc;)

_____

_____

What are your goals with our office? _____

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 services to be performed. It is understood and agreed any x-rays and images are for examination only and the x-rays will remain the property of this office.

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