For Office Use

Patient Intake Form

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: _____
Did you see any other doctors for this condition? ☐Yes ☐No Name of Doctor : _____

Goals in your Health are very Important, we want to make sure that we meet your needs

During the last year, what specific positive or negative events affected your health?

_____

What do you love to do that your current health is preventing your from doing? _____
If you could have perfect health, what would that look like? _____
How does your health challenges affect your significant other or family?

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

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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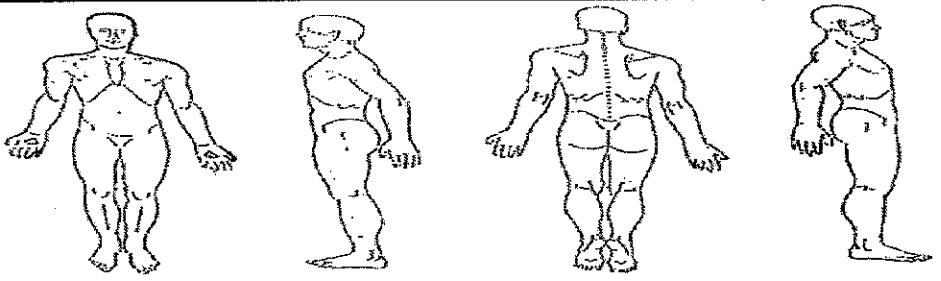
Please mark area(s) of complaint below:



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?

_____

Are you taking any medications? ❑Yes ❑No If yes, which ones?: _____
Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

_____

Do you have a Pacemaker? □Yes □No
Any unexplained weight loss (more than 10 lbs) □Yes □No
Are you having problems with dexterity? (ex- Has it been more difficult to zip up zipper or button up shirt?) □Yes □No
Are you having only issues with walking/gait? □Yes □No
(ex:Do you walk like a drunken person? Do you feel like you are losing balance?)

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 Arthritis, Ehlers-Danlos syndrome, Marfan syndrome, Lupus, Scleroderma)**

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:** _____