New Patient Chiropractic Intake Form

I. General Patient Information

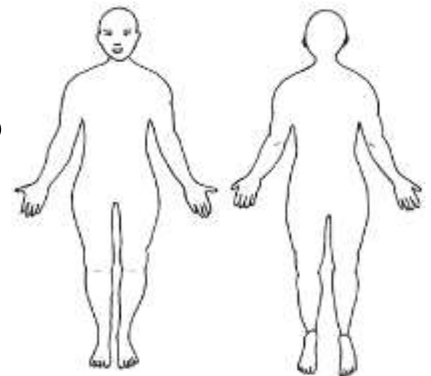
Name:________________________Gender: ○ M ○ F Height:____'____" Weight________lbs
Cell Phone: (_____)____________Email:_____________________________
Address:___________________________________ City, State, Zip Code:__________________________
Date of Birth:____/____/_____ Age:______ Guardian (if under 18):_______________________

Occupation:______________________________ Employer____________________________
Martial Status: ○Single ○Married ○Divorced ○Widow
Spouse's Name:___________________________ Spouse's Occupation:_______________________
Cell Phone*: ____________________________ Home Phone:_________________________
Emergency Contact: _______________________ Emergency Phone:_____________________
Referred by:______________________________

II. Patient Medical History

Primary Complain:____
Secondary Complaint:____

On a Scale from (0-10, 0=no pain, 10=highest) rate your levels of:
Current:_____________Worst:_______________Best:_______________
When did you present pain start (approximately what date)?
○ Suddenly ○Gradually ○Bending ○Lifting
○Twisting ○Pushing ○ Pulling ○After fall (date of fall:________)



Please describe **how** your pain started:
____

What is the **Quality** of the complaint/pain:
○Dull ○Aching ○Sharp ○Shooting ○Burning
○Throbbing ○Deep ○Nagging ○Other

Does this copmlaint/pain **radiate or travel** (shoot) to any areas of your body? Where?________________________________

Do you have any numbness or tingling in your body? Where?____

What activities make your pain **worse?**○
○None ○Lying ○Standing ○Exercise(during) ○Bending forward ○Twisting
○Sitting ○Walking ○Exercise(after) ○Bending backward ○Coughing/Sneezing ○Early
○Ending of day ○Other:______________________

What **reduces** your pain?
○None ○Lying ○Standing ○Bending forward ○Exercise ○Heat/Cold
○Sitting ○Walking ○Pain pills ○Massage ○Acupuncture ○Herb
○Chiropractic treatment ○Physical therapy ○Rest ○Other________________

Have you ever received Chiropractic care? ○Yes ○No If yes, when?__________________________________

Have you ever had **surgery**? ○Yes ○No If yes, what kind?___________________when?_____________________

Do you currently have any mechanical device(like **pacemaker**, etc) in your body? ○Yes ○No If yes,______________

Have you ever **broken** bones? ○Yes ○No If yes,____

Have you ever been in an auto accident? ○Yes ○No If yes,____

(Female only)Are you currently **pregnant**? ○Yes ○No

Is your pain due to work related injury? ○Yes ○No If yes, when?________________________________

Is your pain due to an auto accident injury? ○Yes ○No If yes, when?________________________________

Have you had similar pains in the past? ○Yes ○No If yes, when?________________________________

III. Review of Systems
Please circle any problems that apply to you

○None ○Endocrine/hormonal ○Weakness of arms or legs ○Night pain
○Bladder/bowel ○Sexual Difficulties ○Psychiatric/emotional ○Difficulty sleeping
○Numbness/Tingling of arms and legs ○Other difficulties, what kind______________________

Allergies:____

Previous **illnesses** you've had in your life, **surgeries, hospitalization:**________________________________

Do any of your family members have similar issues to the ones you currently suffer from?
____

Have you had any of the following diagnostic studies?
○X-Rays ○CT Scan ○MRI ○Myelogram ○Dicogram ○EMG/NVS
When?________________________________Which part?________________________________

What medications or supplements are you taking currently and for what conditions?
____

I have read the above information and certify it to be true an correct to the best of my knowledge, and hereby authorize this office of Chiropractic care to treat my condition as deemed appropriate, in accordance with this state's statutes.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged to me are my own personal responsibility, as is their timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature:____________________________________Date:______________