NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

TITLE: MR.☐ MRS.☐ MISS.☐ MS.☐ DR.☐				DATE:
FIRST NAME	INITIAL	LAST NAME		HEIGHT : WEIGHT:
ADDRESS	APT #	CITY	STATE	ZIP CODE
HOME PHONE:	CELL PHONE:	EMAIL ADDRESS:	OCCUPATION:	
BIRTH DATE MONTH/DAY/YEAR	SEX ASSIGNED AT BIRTH:	HOW DID YOU HEAR ABOUT US?		
IN CASE OF EMERGENCY				
CONTACT NAME		TELEPHONE		RELATIONSHIP

MEDICAL INFORMATION

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN'S NAME		PHYSICIAN'S PHONE NUMBER		LAST VISIT
ADDRESS	SUITE	CITY	COUNTY	ZIP CODE
DO YOU HAVE ANY ALLERGIES?	DO YOU TAKE ANY MEDICATION, IF SO PLEASE LIST:			

CHIROPRACTIC INFORMATION

REASON FOR SEEKING CHIROPRACTIC CARE TODAY?	HOW LONG HAVE YOU BEEN SUFFERING WITH THIS CONDITION?

HAVE YOU SOUGHT TREATMENT FROM ANY OTHER HEALTH CARE PROFFESSIONAL? ☐ YES ☐ NO

TREATMENT RECIEVED

HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? ☐ YES ☐ NO *IF YES PLEASE COMPLETE THE FOLLOWING:*

CHIROPRACTOR'S NAME:	LAST VISIT:
REASON FOR SEEKING CARE	RESULTS ☐ GOOD ☐ FAIR ☐ POOR

HEALTH INSURANCE

DO YOU HAVE PRIVATE HEALTH INSURANCE THROUGH A MEDICAL PLAN? NO ☐

☐ YES; MY OWN PLAN	☐ YES; MY SPOUSE'S PLAN D.O.B.	☐ YES; MY PARENTS PLAN D.O.B.
COMPANY: _____	COMPANY: _____ _____	COMPANY: _____ _____
PLAN/POLICY # _____	PLAN/POLICY # _____	PLAN/POLICY # _____
ID/CER/EMP # _____	ID/CER/EMP # _____	ID/CER/EMP # _____

Please check "√" if you are experiencing the following symptoms. Please check all that apply.

General:
- ○ Loss of Consciousness
- ○ Blackouts
- ○ Loss of sleep
- ○ Fever
- ○ Nervousness
- ○ Weight loss
- ○ Excess sweating
- ○ Night Sweats
- ○ Night pain
- ○ Generalized pain
- ○ Headaches
- ○ Convulsions

Neurologic:
- ○ Dizziness
- ○ Fainting
- ○ Blurred Vision
- ○ Double Vision
- ○ Nausea
- ○ Clumsiness
- ○ Numbness & tingling

Muscles and Joints:
- ○ Sore/stiff neck
- ○ Mid back ache
- ○ Low back ache
- ○ Painful tailbone
- ○ Shoulder pain
- ○ Upper limb pain
- ○ Hip pain
- ○ Knee pain
- ○ Ankle/foot trouble
- ○ Arthritis
- ○ Loss of strength

Respiratory:
- ○ Asthma
- ○ Chronic cough
- ○ Difficulty breathing
- ○ Spitting up phlegm/blood

Genitourinary:
- ○ Trouble urinating
- ○ Blood in urine
- ○ Kidney infection
- ○ Bedwetting
- ○ Prostate trouble

Cardiovascular:
- ○ Bleeding disorder
- ○ High blood pressure
- ○ Chest pain
- ○ Stroke
- ○ Hardening of arteries
- ○ Varicose veins
- ○ Swelling of ankles
- ○ Poor circulation
- ○ Heart/blood disease
- ○ Angina

Gastrointestinal:
- ○ Poor appetite
- ○ Indigestion
- ○ Excess hunger
- ○ Belching or gas
- ○ Vomiting
- ○ Pain over stomach
- ○ Constipation
- ○ Diarrhea
- ○ Hemorrhoids
- ○ Jaundice
- ○ Gallbladder trouble

GU for females:
- ○ Menstruation issues
- ○ Breast swelling/lump
- ○ Hot flashes
- ○ Vaginal discharge

Family history:
Cancer ☐ Diabetes ☐ Hypertension ☐ Stroke ☐
Heart Disease ☐

Lifestyle:
Smoking ☐ If so, how much?
Alcohol ☐ If so, how much?
Exercise ☐ If so, how often?
Healthy diet ☐

List all past surgeries:

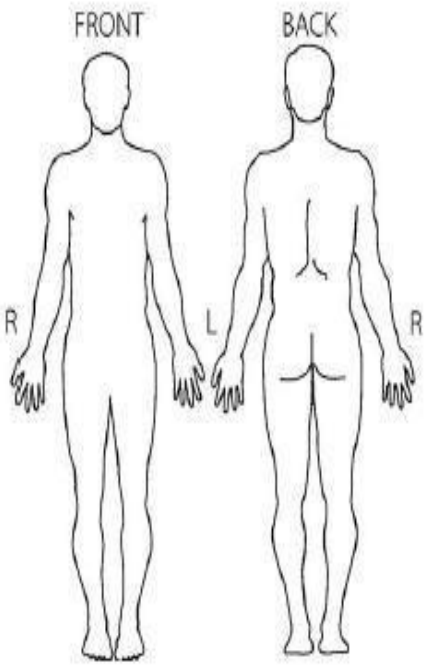
Have you had any **past fractures**? ☐ Yes ☐ No
If yes, where?

Have you ever been diagnosed with:
Cancer ☐ HIV/AIDS ☐ Hep A/B/C ☐

List all **supplements** you are presently taking

Females only: Are you Pregnant? ☐ Yes ☐ No
Due Date:

CHIEF COMPLAINT



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

1

Ache	Burning	Numbness	Tingling	Stabbing/Sharp	Deep
XXXX	+++++	^^^^^^^	*****	//////////	====

2

How did your symptoms start?
- ☐ Sudden
- ☐ Gradual
- ☐ Car accident
- ☐ Work related injury

When did your symptoms start?
- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year or more ago

3

Please mark on the line below the level or your discomfort

0 — No pain

10 — Worst pain