Patient Intake

Date of Birth____________________ Email Address ___________________________________

Last Name _________________________ First ______________________ SS#: _____-______-_______

Address ______________________________Apt # _____ City _____________ ST_____ Zip __________

Phones: (H) _______________ (W) _____________-Ext ______ (Cell) ______________ Best #: H W C

I hereby give my permission to contact me at (circle if OK): Home Work Cell Initials: _______

Spouse's Name ____________________ *May we discuss your care with your spouse?* (circle) Yes No

Your Occupation ________________________________ Employer _____________________________

Employer Address ______________________________ City _____________ State _____ Zip _______

Have you ever been to another doctor for this problem? Yes No

Who? _____________________ MD DO DC Other: ________ City _____________ ST ________

Who referred you to this office? ______________________ Approx. How Long Ago: ___ wks- mos- yrs

What Brings You to Our Office?

FIRST COMPLAINT (be specific): ____

- Date when symptom first appeared (at least the year) ____________________________________
- Problem began ___Gradually ___ Suddenly If so, what happened? _______________________
- What makes it *worse*? ____
- What makes it *better*? ____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb Other _________
- The pain radiates into my: _____ Arm Rt Lt _____ Leg Rt Lt _____ Does not radiate
- Do you experience numbness or tingling? _____Y _____N
- What percentage of the time are you aware of the problem?
  _____100% _____75% _____50% _____25% _____10%
- PAIN INTENSITY: Please put an **X** on the line below describing the intensity of your pain.

No Pain ____ Unbearable Pain

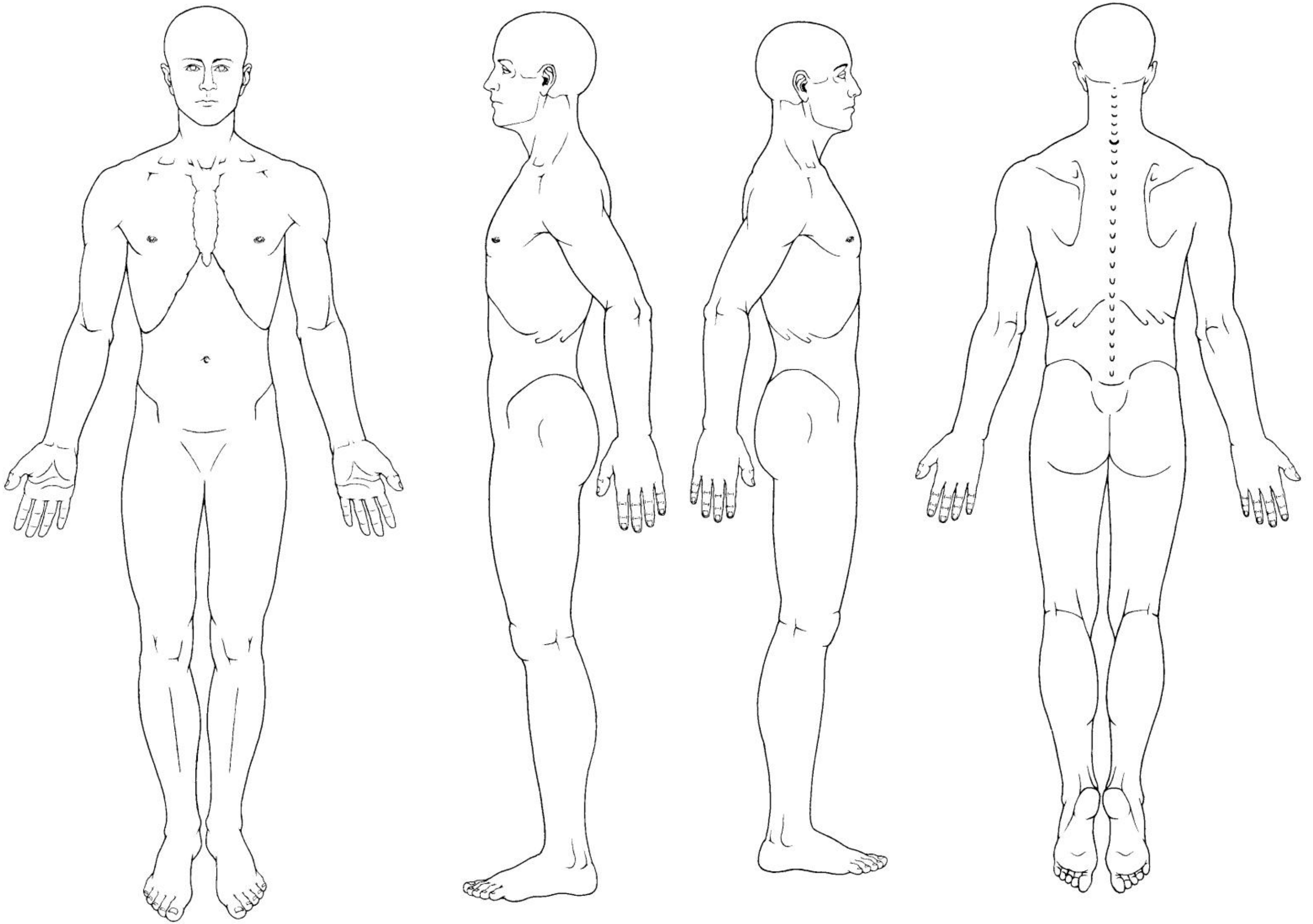
SECOND COMPLAINT (be specific): ____

- Date when symptom first appeared (at least the year) ____________________________________
- Problem begin ___Gradually ___ Suddenly If so, what happened? _______________________
- What makes it *worse*? ____
- What makes it *better*? ____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb Other _________
- The pain radiates into my: _____ Arm Rt Lt _____ Leg Rt Lt _____ Does not radiate
- Do you experience numbness or tingling? _____Y _____N
- What percentage of the time are you aware of the symptoms?
  _____100% _____75% _____50% _____25% _____10%
- PAIN INTENSITY: Please put an **X** on the line below describing the intensity of your pain.

No Pain ____ Unbearable Pain

PAIN LOCATION

PATIENT INTAKE



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
SSS	**Where you experience Stiffness**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

Patient Intake

SYSTEMS REVIEW

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name ____ DATE ____________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O-OCCASIONAL
F-FREQUENT
C-CONSTANT

(Columns: O F C)

GENERAL
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness/depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

MUSCLE & JOINT
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain or stiffness
- ☐ ☐ ☐ Pain between shoulders

Pain or numbness in:
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tail bone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal Curvature
- ☐ ☐ ☐ Swollen joints

GASTRO-INTESTINAL
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Distension of abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gall bladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE & THROAT
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noises
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

CARDIO-VASCULAR
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heart beat
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

SKIN
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control kidneys
- ☐ ☐ ☐ Kidney infection or stones
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge
- ☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Patient Intake

HISTORY

What's your major complaint? ________________________________

____

List surgical operations and years: ________________________________

____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills
Others: ________________________________

Age of mattress: ____________ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? ____________
Describe: ________________________________

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ past five years ☐ Over five years ☐ Never
Describe: ________________________________

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ____________
Have others in your family had such disorders? ☐ Yes ☐ No When? ____________

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	____________
Used a cane, crutch, or other support?	☐	☐	____________
Been treated for a spine or nerve disorder?	☐	☐	____________
Had a fractured bone?	☐	☐	____________
Been hospitalized for anything other than surgery?	☐	☐	____________

DO YOU:			
Now take vitamins or minerals?	☐	☐	____________
Think you may need vitamins or minerals?	☐	☐	____________
Have an allergy to any drug?	☐	☐	____________

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME ________________________________

ADDRESS: ________________________________ PHONE: ____________

Patient Intake

Please list all previous treatments for this condition:

Name of Treating Physician ________________________________ Dates of Treatment __________

Type of Treatment or Drugs Prescribed ____

Name of Treating Physician ________________________________ Dates of Treatment __________

Type of Treatment or Drugs Prescribed ____

Name/Address of Family Doctor:

Please list all past surgeries (regardless of what kind and year):

Type ____________________________ When ______________ Doctor ___________________

Type ____________________________ When ______________ Doctor ___________________

Type ____________________________ When ______________ Doctor ___________________

Type ____________________________ When ______________ Doctor ___________________

Please list all previous accidents and falls (even ***"minor ones",*** regardless of what kind and year):

What ____ When ____________________

What ____ When ____________________

What ____ When ____________________

Please list any medications or vitamins you are currently taking (use separate sheet if necessary):

____

I usually eat 21 meals per week with no less than 3 oz. of protein (meat, fish, fowl, cheese, eggs) per meal. True False

Vascular Risk evaluation

*Have you ever suffered a stroke? Y N *Anyone in your family had a stroke Y N

Who / Age ____

*Have you ever had a heart attack? Y N *Anyone in your family had a heart attack Y N

Who / Age ____

*Do you have a vascular disease? Y N *Anyone in your family have a vascular dx Y N

Who / Age ____

*Do you have high BP Y N *Anyone in your family have high BP Y N

Who / Age ____

Do you smoke? Y N How much ______________ How long ________________

Have you ever smoked in the past? Y N When did you quit? __________________________

Do you take birth control pills? Y N Have you ever taken birth control pills? Y N

*If the answer to any of the questions with a * is yes, then an upper vascular study might be considered prior to any cervical adjustments.*

Patient's/Guardian's Signature ____________________________________ **Date** ________________

STOP!