Chiropractic

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New Patient Intake Form

Date:_____

Name:_____ DOB:_____ Age:_____ Sex: M / F

Home Phone #_____ Cell #_____ Work #_____

Address: _____ City: _____State: _____Zip: _____

Email: _____

Marital Status: M / S / D / W Children: Y / N Ages: _____

Who may we thank for referring you? _____

Your hobbies: _____

Do you exercise? Y / N How often? _____ What type? _____

Diet: Healthy / Ave / Poor Vitamins/supplements? Y / N Alcohol: Never/Rare/Moderate/Daily

Have you consumed alcohol in the last 24 hours: Y / N When? _____

Smoker: Y / N Packs per day:_____ How Long:_____ Past Smoker Y / N Date Quit:_____

Occupation: _____ Employer: _____

Insurance Company: _____ Policy #: _____

Spouse's name: _____ Spouse's DOB: _____

Occupation: _____ Employer: _____

Insurance Company: _____ Policy # _____

Treatment and Finances: First and foremost the priority in this office is to provide the highest quality of care to all patients. As a courtesy our office will provide each patient with a detailed invoice that can be submitted to insurance for reimbursement directly ***from your insurance company to you***. Please be sure to let us know if you would like an invoice. Though we are happy to provide you with this, it is our policy to collect payment in the office at the time of service.

☐ I understand that payment is due at time of service and as a courtesy this office will provide me with a detailed invoice that may be submitted to my insurance company.

☐ I have questions about this policy or have other financial related concerns and would like to speak to someone in the office about this.

As a society we are ranked 50th in the world when it comes to health, yet in our Chiropractic office we take pride in helping people to reach their optimum health and wellness. In order to help you best, we would like an honest assessment of where you believe your current level of health is. So please place an "X" on the scale below marking where you believe your level of health and wellness is at this time. Then place a circle "O" on the diagram indicating where you would like your health and wellness to be.

Very Poor Challenged Less Than Ideal Generally Good Ideal Health

Patient Health Profile

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Primary Health Concern: _____

When did your health challenge start? _____ Is it getting worse? Yes / No

How often are you in pain? _____ Is it constant? Yes / No

Rate the severity of your pain on a scale from 1 (least) to 10 (severe):

Current Today_____ Worst Ever _____ Average_____

Type of pain: (Circle all that apply)

Sharp / Dull / Throbbing / Numbness / Aching / Shooting / Burning / Tingling

Cramps / Stiffness / Swelling / Other:_____

Does it interfere with: Work / Sleep / Daily Routine / Recreation

Activities that make problems worse: Sitting / Standing / Walking / Bending / Lying Down / _____

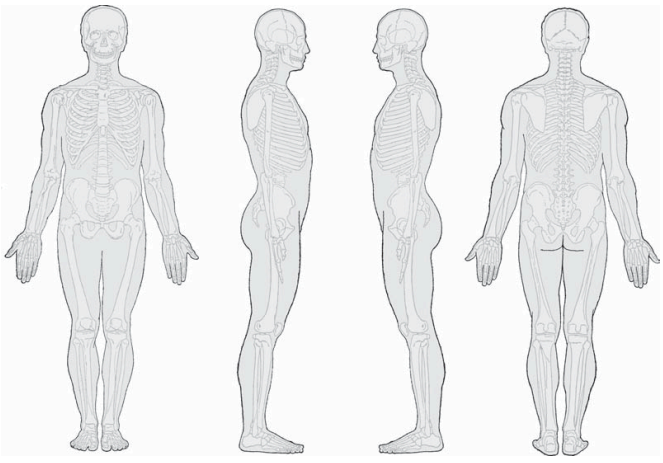
Activities that make problems better: _____

Have you received any other type of treatment for this health concern? Y / N _____

If Yes, was the cause of your health concern identified? Y / N _____

If Yes, what was the recommended course of care? _____

Have you had previous chiropractic wellness care? Y / N Details: _____



Please mark your areas of pain on the diagram on the left.

Please mark a "X" at the level of your pain on the scale to the right.

Worst Pain Possible

No Pain

General History

Given that all prescription medications have side effects, some very serious, please tell us what prescription or over the counter medications you are currently taking and why.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Supplements are becoming more popular these days as people are looking for more natural ways to manage their own health and wellbeing. Please tell us what supplements you are taking and why.

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any traumatic injuries or car accidents:

_____
_____
_____
_____

List all surgeries/hospitalizations and dates:

_____
_____
_____
_____

List any doctors you are currently seeing

_____
_____
_____
_____

Do you have any of the symptoms below today?

- ☐ Sunburn
- ☐ Swelling
- ☐ Headache
- ☐ Cold / Flu
- ☐ Open Cuts, Bruises, Burns
- ☐ Irritated Skin Rash
- ☐ Poison Ivy
- ☐ Fever

Slips and falls, although common have a direct impact on your health and wellbeing. Even MINOR falls or accidents can cause long term stress, strain and damage to the spine. In addition to the traumatic injuries listed above, please list any additional slips, falls, etc that you can recall, even if minor.

_____ _____
_____ _____

"The doctor of the future will give no medication, but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease.

- Thomas Edison

Life is not merely to be alive, but to be well.

- Marcus Valerius Martial

Health Concerns Checklist - Please indicate on the list below, "C" for current or "P" for past.
Because the Nervous system controls everything in your body, it is common that current health challenges can be related to the problems you are seeking care for in our office. Please indicate if you currently have or have had any of the following symptoms or health conditions.

__ AIDS/HIV
__ Alcoholism
__ Allergies
__ Anemia
__ Anorexia
__ Appendicitis
__ Arthritis
__ Asthma
__ Back Pain
__ Bleeding Disorders
__ Breast Lump
__ Bronchitis
__ Bulimia
__ Cancer
__ Chemical Dependence
__ Constipation
__ Cold Hands
__ Cold Feet
__ Cold Sweats
__ Chicken Pox
__ Depression/Anxiety
__ Diabetes
__ Diarrhea
__ Dizziness
__ Emphysema
__ Epilepsy
__ Fainting
__ Fatigue
__ Fever
__ Fractures
__ Glaucoma
__ Goiter
__ Headaches
__ Heartburn
__ Heart Disease
__ Hepatitis
__ Hernia
__ Herniated Disk
__ High Blood Pressure
__ High Cholesterol
__ Hot Flashes
__ Irritability
__ Kidney Disease
__ Lights Bother Eyes
__ Liver Disease
__ Loss of Balance
__ Loss of Smell
__ Loss of Taste
__ Measles
__ Menstrual Pain
__ Menstrual Irregularity
__ Miscarriage
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Neck Stiffness/Pain
__ Nervousness
__ Numbness in Arms
__ Numbness in Fingers
__ Numbness in Hands
__ Numbness in Legs
__ Numbness in Toes
__ Osteoporosis
__ Pacemaker
__ Parkinson's
__ Pinched Nerve
__ Pneumonia
__ Polio
__ Prostate Problem
__ Prosthesis
__ Psychiatric Care
__ Rheumatoid Arthritis
__ Rheumatic Fever
__ Ringing in the ears
__ Scarlet Fever
__ Sleeping Problems
__ STD
__ Stroke
__ Suicide Attempt
__ Tension
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Tumors/Cysts
__ Typhoid Fever
__ Ulcer
__ Upset Stomach
__ Urinary Tract Inf.
__ Vaginal Infection
__ Whooping Cough

If you have any additional health concerns not listed above, please indicate below:

_____ _____
_____ _____
_____ _____

FAMILY Health History
Please mark below any conditions that apply to your ***FAMILY*** health history.

__ High Blood Pressure
__ Heart Disease
__ Emphysema
__ Seizures
__ HIV Positive
__ Asthma
__ Diabetes
__ Kidney Disease
__ Back Problems
__ Ulcer / Stomach Problems
__ Arthritis
__ Mental Illness
__ Headaches
__ Circulation Problems
__ Cancer
__ Osteoporosis

Lifestyle Questions

It has been shown that daily lifestyle stress significantly impacts your overall health and wellbeing. As a family wellness office we specialize in not only addressing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health and wellness.

Please rate the following categories 1-10 AND circle ALL answers that apply to your habits:
(1 being very poor and 10 being excellent)

Eating Habits _____

A. I eat 3-5x's a day
B. I eat fruits and vegetables daily
C. I eat out 2-3 times weekly (min)
D. I drink 3-5 sodas weekly
E. I crave sweets
F. I don't watch what I eat

Exercise Habits _____

A. I exercise 3-5 times a week
B. I walk daily
C. I don't exercise
D. I want to exercise
E. I sit (at a computer) 6-8 hours a day

Sleep _____

A. I sleep 7-9 Hours a night
B. I wake up well rested
C. I wake up tired
D. I toss and turn
E. I stay up late

Mind Set _____

A. I have a positive outlook
B. I am generally in a good mood
C. I share my feeling easily
D. I have a negative outlook
E. I am generally in a bad mood
F. I bottle things up inside

General Health _____

A. I am not on medication
B. I take care of myself
C. I watch what I eat
D. I base my health on what everyone around me is doing
E. I think I am healthy but know I could make some changes to be even healthier

On a scale of 0-10 please describe your levels of stress in the following categories of health:
(0= none / 10=extreme)

Occupational _____ Social _____ Emotional _____ Spiritual _____
Physical _____ Mental _____ Environmental _____

You're Almost There

Thank you for providing us with the information that can help us to better serve you and help you to be in the best health you can be!

Health Goals

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. In order for us to truly help you to be as healthy as possibly, it is important that we understand your goals for your overall health and wellbeing.

Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutrition Goal	Stress / Emotional Goals

How can we help you?

It is our goal with every patient that they might live a LONGER, HAPPIER, and HEALTHIER life in some way as a result of the care, education, and inspiration they receive in this office. Though this is our desire, we want to know how you feel. Please answer the following questions.

If we find that there is a need for you to make dietary changes, would you like our recommendations?
_____Yes _____No

If we find that there is a need for you to begin general or specific exercises would you like our recommendations?
_____Yes _____No

If we find there is a need to address emotional or physical stress in your life, would you like our recommendations?
_____Yes _____No

- On a scale of 1-10, with 10 being the highest, how much do you want to get rid of your health problems and move toward wellness, so that you can function better and feel great? _____
- Assuming that we could help you with your conditions or health concerns, is there anything that would prevent you from following through with a treatment plan? _____Yes _____No
- At our office we are always here to answer any questions you have about your health or your care at our office. If you have any questions or concerns now, please specify below.

_____

_____

Thank you for taking the time to complete all the information necessary to assess you health concerns and goals so we can begin to help you along the path to wellness!

I consent to a complete chiropractic examination and any other diagnostic testing that the doctor deems necessary. I understand the doctor will do their best to explain as much as possible about procedures pertaining to testing and care, and that if I have questions at any time I will ask.

Signature_____ Date_____