New Patient Intake Form

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Patient Information

Last Name ____________________ First Name ____________________ MI ___ Preferred Name ____________

DOB ___/_____/______ SSN _____-___-______ ☐ Male ☐ Female Relationship Status ☐ Single ☐ Divorced

Street Address ____ Apt. # __________ ☐ Married ☐ Widowed

City _________________________ State __________________ Zip ____________ ☐ Separated

Email _____________________________ Phone ________________________ Alt. Phone _______________

Preferred method of contact ☐ Email ☐ Text ☐ Phone Call

Is it ok to leave detailed messages about your appointments/health care? ☐ Yes ☐ No

Would you like to be added to our email list for newsletters, schedule changes, updates, etc.? ☐ Yes ☐ No

Whom may we thank for referring you to us? ____

Employment Information

Occupation _____________________________________ ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Employer ____ Duration ____________________________

Emergency Contact Information

Whom should we contact? ______________________________________ Relation ______________________

Phone Number __________________________________ Cell Number ______________________________

Patient Past Health History

Do you have a history of major trauma/injury? (broken bones, car accidents, concussions) ☐ Yes ☐ No

If yes, please describe ____

____

Have you had any surgical procedures, outpatient procedures and/or hospitalizations? ☐ Yes ☐ No

If yes, please describe ____

____

Have you had a previous or current diagnosis of cancer? ☐ Yes ☐ No If yes, when? _____________

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Social History

Number of Children & Ages ______________________ ☐ N/A I don't have children

Exercise ☐ None ☐ 1-3 times/week ☐ 4-6 times/week ☐ Daily What types? ______________

Alcohol Use ☐ None ☐ Monthly ☐ Weekly ☐ Daily How much? ______________

Do you use recreational drugs? ☐ Yes ☐ No

Do you currently or previously used tobacco products? ☐ Yes ☐ No

If so, what types? ______________ How often? ______________ How long? ______________

I quit using tobacco products on this date ___/___/___ ☐ N/A, I still utilize

Family History

Use the following indicators: **M**= Mother **F**= Father **SI**= Sister **B**= Brother **D**= Daughter **SO**= Son

M F SI B D SO **HEART CONDITIONS**
(Heart Disease, Hypertension, Heart Murmurs, Genetic Defects)

M F SI B D SO **INFLAMMATORY CONDITIONS**
(Rheumatoid/Psoriatic Arthritis, Gout, Crohn's Disease/Ulcerative Colitis, Other Autoimmune or Auto Inflammatory Conditions)

M F SI B D SO **CIRCULATORY CONDITIONS CONDITIONS**
(Stroke, Hemophilia, or other)

M F SI B D SO **GENETIC DISEASES (PLEASE LIST)**
____

M F SI B D SO **OSTEOPOROSIS OR OTHER BONE DENSITY DISEASE/CONDITION**

Current Medical Conditions

In the past 3 months have you had or are you experiencing
☐ Fever / Chills / Sweats
☐ Unexplained Weight Change (More Than 10 Lbs)
☐ Difficulty Sleeping Due To Pain

Last physical exam ______________ Primary Care Physician ______________ Clinic ______________

Current medication list *please indicate dosage (if known), frequency, and any over-the-counter medications, vitamins/supplements*

____

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Current Medical Conditions Continued

Do you have any medication allergies? ☐ Yes ☐ No If so, what? ______________________________

Have you previously been under chiropractic care? ☐ Yes ☐ No If so, when? ____________________

Do you tolerate manual adjusting (hands-on)? ☐ Yes ☐ No If no, please explain ________________

____

____

Are there any preferences you would like us to know about your chiropractic care?

____

____

Reason for today's visit

PRIMARY COMPLAINT

Describe your symptoms ____

When did it start? ____________ How are your symptoms changing? ☐ Getting Better ☐ Getting Worse ☐ No Change

How often do you notice these symptoms? ☐ 100%-76% ☐ 75%-51% ☐ 50%-26% ☐ 25%-0

Rate your pain (0= no pain, 10= unbearable pain)

At its best 0 1 2 3 4 5 6 7 8 9 10 At its worst 0 1 2 3 4 5 6 7 8 9 10

SECONDARY COMPLAINT

Describe your symptoms ____

When did it start? ____________ How are your symptoms changing? ☐ Getting Better ☐ Getting Worse ☐ No Change

How often do you notice these symptoms? ☐ 100%-76% ☐ 75%-51% ☐ 50%-26% ☐ 25%-0

Rate your pain (0= no pain, 10= unbearable pain)

At its best 0 1 2 3 4 5 6 7 8 9 10 At its worst 0 1 2 3 4 5 6 7 8 9 10

OTHER COMPLAINT

Describe your symptoms ____

When did it start? ____________ How are your symptoms changing? Getting Better Getting Worse No Change

How often do you notice these symptoms? ☐ 100%-76% ☐ 75%-51% ☐ 50%-26% ☐ 25%-0

Rate your pain (0= no pain, 10= unbearable pain)

At its best 0 1 2 3 4 5 6 7 8 9 10 At its worst 0 1 2 3 4 5 6 7 8 9 10

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History of Complaint(s) continued

What makes your symptoms better? ____

____

What makes your symptoms worse? ____

____

Are your symptoms worse at certain times of day? ☐ Yes ☐ No If so, please explain ______________

____

Have you been seen by anyone for this condition? If so, date seen ____/____/____

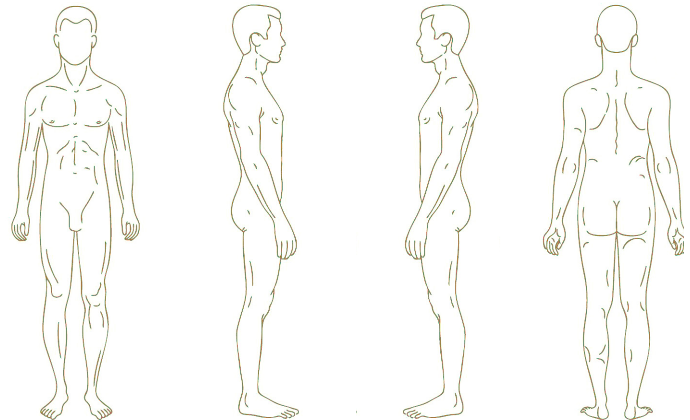
☐ No one ☐ Medical Doctor ☐ Physical Therapist ☐ ER ☐ Other Chiropractor ☐ Other ____________

Have you had similar symptoms in the past? ☐ Yes ☐ No If so, when? ______________________

Describe your symptoms

Using the adjacent body charts, please indicate all affected areas and symptoms if you are experiencing them.

//	=	STABBING PAIN
B	=	BURNING PAIN
D	=	DULL PAIN
A	=	ACHING PAIN
SW	=	SWELLING
C	=	CRAMPS
T	=	TINGLING
ST	=	STIFFNESS
N	=	NUMBNESS



Do you have any loss of bowel or bladder control, changes in smell, taste, hearing, vision, speech, difficulty swallowing or with facial expression? ☐ Yes ☐ No If so, please explain ______________________

____

Your Chiropractic Care

What are you hoping to achieve through chiropractic care? ______________________________

____

Are there activities in your life you are currently unable to do that you would like to be able to do again? Please explain.

____

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Review of symptoms
Please mark any of the conditions below that apply to you, past or present.

General Health
- ☐ None
- ☐ Fever
- ☐ Chills
- ☐ Unexplained/Unintentional Weight Loss/Gain
- ☐ Other ________________

Head/Eyes/Ears/Nose/Throat
- ☐ None
- ☐ Head injury
- ☐ Dizziness
- ☐ Light-headedness
- ☐ Changes in Vision
- ☐ Eye Pain
- ☐ Redness of Eyes
- ☐ Excessive tearing
- ☐ Double/ blurred vision
- ☐ Seeing spots/specks or flasing lights
- ☐ Sore Throat
- ☐ Dry Mouth
- ☐ Hoarsness
- ☐ Other ________________
- ☐ Changes in hearing
- ☐ Tinnitus
- ☐ Vertigo
- ☐ Discharge
- ☐ Frequent Colds
- ☐ Nasal Stuffiness
- ☐ Discharge/Itching of the nose
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Chronic Sinus Complaints
- ☐ Swollen Glands
- ☐ Goiter
- ☐ Lumps or pain in neck

Skin/Hair/Nails
- ☐ None
- ☐ Rashes
- ☐ Lumps
- ☐ Sores
- ☐ Blisters
- ☐ Growths
- ☐ Itching
- ☐ Dryness
- ☐ Changes in Hair or Nails
- ☐ Changes in Size/ Shape of Moles
- ☐ Other ________________

Reproductive (Female)
- ☐ None
- ☐ Abnormal Discharge Or Bleeding
- ☐ Excessive Menstrual Bleeding
- ☐ Abnormal Frequency Or Duration Of Menstrual
- ☐ Cycles PCOS
- ☐ Lumps Or Discharge From Breasts
- ☐ Infertility
- ☐ Other ________________

Reproductive (male)
- ☐ None
- ☐ Discharge
- ☐ Sores
- ☐ Pains
- ☐ Masses
- ☐ Swelling
- ☐ Infertility
- ☐ Erectile Dysfunction
- ☐ Other ________________

Heart/Cardiovascular
- ☐ None
- ☐ Chest Pain or Pressure
- ☐ Arrhythmia or Palpitation
- ☐ Shortness of Breath
- ☐ Swelling/Edema
- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ Cramping in Thighs
- ☐ Other ________________

Gastrointestinal System
- ☐ None
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Reduced Appetite
- ☐ Bloody or Black Tarry
- ☐ Stool Frequent Urination
- ☐ Pain or Burning During Urination
- ☐ Flank Pain
- ☐ Other ________________

Endocrine
- ☐ None
- ☐ Heat or Cold Resistance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Other ________________

Psychiatric Conditions
- ☐ Diagnosis ________________
- ☐ No diagnoses

Neurologic
- ☐ None
- ☐ Headache
- ☐ Vertigo
- ☐ Fainting
- ☐ Blackouts
- ☐ Weakness
- ☐ Paralysis
- ☐ Tremors
- ☐ Seizures
- ☐ Numbness or loss of sensation
- ☐ Tingling or feeling of 'pins and needles'
- ☐ Changes in mood, attention or speech
- ☐ Changes in orientation/ memory/judgement

Other ________________

Respiratory
- ☐ None
- ☐ Wheezing
- ☐ Other ________________
- ☐ Cough
- ☐ Shortness of Breath

Allergic/Immunologic
- ☐ None
- ☐ Hay Fever
- ☐ Immune Deficiencies
- ☐ Other ________________

Hematologic/Lymphatic
- ☐ None
- ☐ Abnormal Bleeding
- ☐ Other ________________