Normal
CHIROPRACTIC

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issue you face and ensure the best possible treatment.

New Patient Intake Form

Demographics

Name _____ Date _____
Date of Birth _____ ( ) Male ( ) Female
Address _____
_____
Phone # (_____) _____ E-mail _____
Occupation _____ How did you hear about us? _____
Emergency contact _____ Relationship _____ Phone # (_____) _____
Do you have Medicare or Medicaid? _____
Is your condition due to an accident? _____

Condition

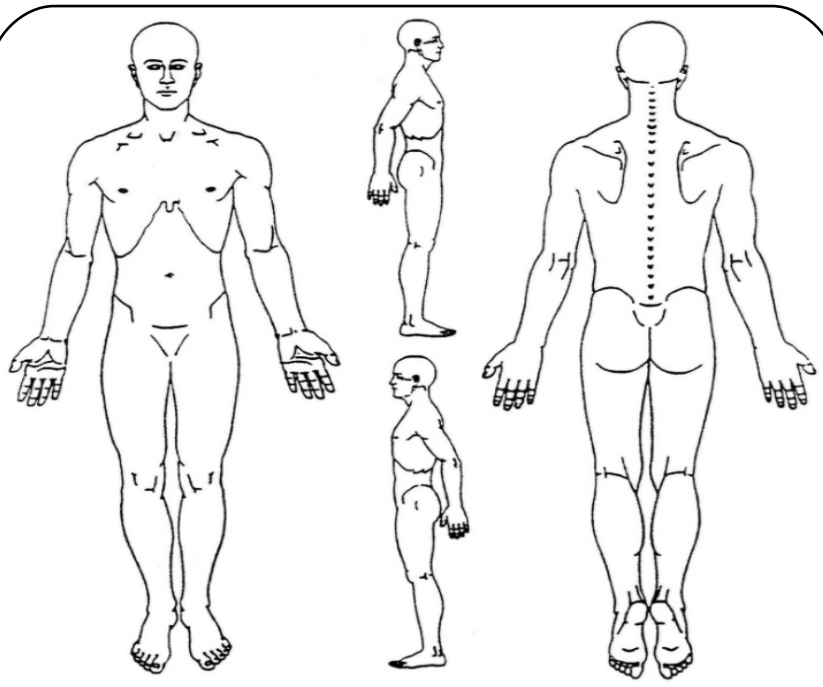
Reason for visit _____
Give a brief description of the problem(s) _____
_____
_____
_____
What are your goals with care? ( ) Pain relief ( ) Wellness ( ) Other _____
How long have you had this condition? _____ Is it getting better/worse? _____
What seemed to be the initial cause? _____
How often do you have this pain? _____ Is it constant? _____
Rate the severity of your pain from 0 (no pain) to 10 (worst pain imaginable) _____
Have you been treated for this condition in the past? By who? _____
If so, what have you had done? _____

Have you had any imaging done?
(X-ray, MRI, CT, Ultrasound)
_____
_____
_____

Have you had any relevant surgeries?
_____
_____
_____

Are there any related medical conditions that we should be aware of?
_____
_____
_____

Please mark any and all areas of pain, numbness, etc.



Past Health History

Check and indicate the age when you had any of the following

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis
  Type? _____
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defecation
- ☐ Vomiting

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Coughing up phlegm / blood
- ☐ Wheezing

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Angina
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of the ankles

Genitourinary
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Incontinence
- ☐ Painful urination
- ☐ Decreased urinary flow

Women only
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Miscarriage
- ☐ PCOS / Ovarian cyst
- ☐ Vaginal discharge

Are you pregnant?
- ☐ Yes
  How many months?
  _____
- ☐ No

Health Conditions
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
  Type? _____
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Myofascial pain syndrome
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications you are currently taking

_____
_____
_____
_____
_____

- ☐ Have you been hospitalized in the last 5 years? If so why? _____
- ☐ Have you ever broken any bones? If so what? _____
- ☐ Are you under the care of a Neurologist, Rheumatologist or Orthopedist? _____

Family History

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleed easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____