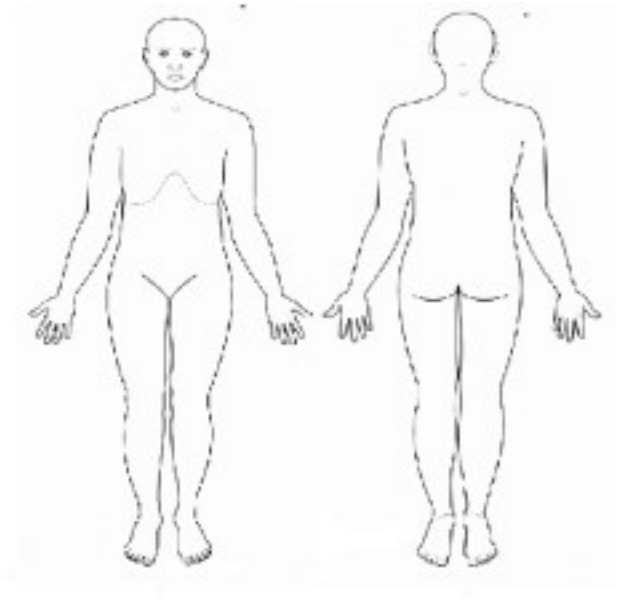
New Patient Intake Form

First Name _____ Middle Initial ____ Last Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone (_____) _____-_____ ____ Cell Phone (_____) _____-_____
Social security #____-_____-_____Email _____
Date of Birth _____/_____/_____ Sex: Male Female **Marital Status:** Single Married Other
Children: Yes No **Ages:_____**
Employment Status: Employed Unemployed FT Student PT Student Other_____

<u>Emergency Contact</u>
Contact Name _____ Relationship to Patient _____
Contact Phone (_____) _____-_____

Would you like us to verify your health insurance coverage? Yes No
How did you hear about our office? Website Facebook Referral/other_____
Do you have a primary complaint?_____
When and how did it begin? _____
What makes it better?_____Worse? _____
(*Women Only) Are you pregnant? Yes_____ No _____Uncertain_____



Please mark on the diagram where your pain is occurring.

If you are currently experiencing pain, is it: (***Mark all that apply)***

Sharp _____ Dull Ache _____ Burning _____
Throbbing _____ Stabbing _____ Shooting _____
Numbness _____ Tingling _____

Does the pain: Come and go Constant

How often does the pain occur? *Hourly___*
Daily___ Weekly___ Occasionally___ N/A___ **If the pain travels, where does it go?_____**

How would you rate your pain? (0 = no pain, 10 = worst pain possible): 0 1 2 3 4 5 6 7 8 9 10

Since the onset, has the complaint? *Improved___*
Worsened___ Stayed the same___ N/A___

Is this keeping you from...
Working___ Exercising___ Sports/hobbies___ Driving___ Sleeping___ Family Time___

How would you rate your HEALTH right now? (0 = Unhealthy, 10 = Optimum Health)
0 1 2 3 4 5 6 7 8 9 10

Have you ever been under chiropractic care? If so, when?
_____

Following, is a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Mark the following conditions that are CURRENTLY a cause of significant concern.

Current Significant MUSCULOSKELETAL concerns:

Back/Neck Pain____ Carpal Tunnel____ Scoliosis____ Joint Pain_____ Leg Pain/Sciatica____ Headaches___ Arthritis____ Swollen Join____

Current Significant CARDIOVASCULAR concerns:

Chest Pain/Angina_____ Blood Pressure Issues_____ Anemia_____ Cold Extremities_____ Varicose Veins_____ Heart Problems _____ Arterio/Athero Sclerosis_____ Stroke_____

Current Significant GASTRO-INTESTINAL concerns:

Abnormal Appetite_____ Nausea_____ Constipation_____ Bad Breath_____ Ulcers_____ Increased Thirst_____ Vomiting_____ Bloating/Gas_____ Heartburn_____ Diarrhea_____ GERD/Acid Reflux_____ Gall Stones_____

Current Significant URINARY/REPRODCUTIVE concerns:

Kidney Infection_____ Bladder Trouble_____ Fibroid_____ Hot Flashes_____ Cramps_____ Cysts_____ Impotence_____ Kidney Stones_____ Frequent Urination_____ PMS_____ Excessive Menstruation_____ Prostate Problems_____ Painful Urination_____ STD's_____ Decreased Sex Drive_____ Painful Menstruation_____ Endometriosis_____ Pregnant_____ Discolored Urination_____ Hemorrhoids_____

Current Significant NERVOUS SYSTEM concerns:

Nervousness_____ Shooting Pain_____ Seizures_____ Dizziness/Vertigo_____ Anxiety_____ Paralysis_____ Loss of Balance_____ Loss of Taste_____ Numbness/Tingling_____ Forgetfulness_____ Loss of Smell_____

Current Significant GENERAL concerns:

Allergies_____ ADD/ADHD_____ Diabetes_____ Herpes Zoster/Simplex_____ Fatigue_____ Colic_____ Autism_____ Hearing_____ Insomnia_____ Lung Problems_____ Dental_____ Heart Disease_____ Depression_____ Cancer_____ Chicken Pox_____ Vision_____

List All Current Medications (include all over counter, supplements, and herbs): _____

_____

_____

_____

List any accidents or traumas, when they the-happened, and what was injured: _____

_____

_____

_____

Name of Primary Care Physician and Approx. Date of Last Visit: _____ Have you been treated for any conditions in the last year? Yes No

If yes, please explain:_____ Please include any additional information, concerns, or questions you would like to add:

_____

_____ The statements made as to the questions asked on this form are accurate to the bets of my knowledge and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form and in the file will remain confidential to myself, the doctor, and any other authorized personnel. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

Signature_____ **Date**_____