NEW PATIENT INTAKE FORM

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Cell: _____ Marital status: M / W / D / S

Birth date: _____/_____/_____ Age: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone #: _____

Who may we thank for referring you? _____

Chiropractic experience- How often were you going and for how long?: _____

Last time you went to previous doctor of chiropractic: _____

General practitioner: _____ City: _____

EMPLOYMENT & FAMILY INFORMATION

Your employer: _____

Occupation: _____Navy? How long stationed here?_____

Spouse's name: _____

Spouse's employer: _____

Children's names & ages: _____

Favorite hobbies or interests: _____

HEALTH REASONS FOR CONSULTING OUR OFFICE

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY

Have you had the same or similar problem(s) before? ___ Yes ___ No

How long? _____ Please explain: _____

_____

Family members with similar problems?

_____

Is this the result of an auto or work injury? _____ If so, when? _____

Other doctors who have treated this problem: _____

Surgeries you have had: _____

Medication(s) you currently take: _____

Have you ever been diagnosed with cancer? _____ If so, what type? _____

Is there any chance you are pregnant? Yes ___ No ___

Pregnancy Due Date: _____ OBGYN: _____

TRAUMA HISTORY

When was your most recent car accident? When was the last accident prior to this one?

Impacts as little as 5mph cause scar tissue to form in your spine

_____

_____

As a child were you athletic: what sports did you play? What are some sports or activities you are currently involved in? _____

_____

Any major slips, trips, or falls resulting in sprains, strains, or broken bones? Have you ever fallen down the steps? (Trampoline, slips on stairs or ice, rough housing as a kid)

Your body remembers each and every impact through fibrosis or scar tissue

_____

_____

Pregnancy Complications/Experience/Delivery/Breastfeeding/Difficulty getting pregnant?

Momiversary Date: (First child's birth month)_____

_____

_____

Have you ever had headaches or back pain which caused you to miss work? Describe typical positions and activities you regularly do at work.

Sitting for long periods causes weaknesses in the spine

_____

_____

FOLLOW UP QUESTIONS

Headaches/Migraines? _____

Digestion Issues? Bloating/Constipation/Reflux_____

Menstrual Cycle Issues? _____

Anxiety/Stress or Depression? _____

Issues falling or staying asleep? _____

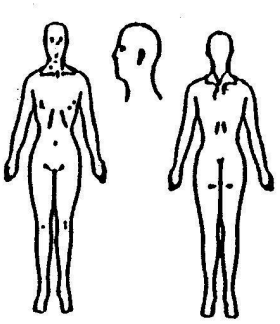
Other Diagnoses or Surgeries: _____

How is this symptom impacting your life?

- ☐ Work
- ☐ Exercise
- ☐ Recreations
- ☐ Relationships
- ☐ Sleep
- ☐ Energy
- ☐ Attitude
- ☐ Patience
- ☐ Productivity
- ☐ Creativity

CHIEF COMPLAINT #1

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury?

_____

_____

What makes it better/worse?

Better: _____

Worse: _____

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing Other: _____

Does it travel? Yes / No If yes, where? _____

Any numbness/tingling (in hands or feet)? _____

Out of 10: _____/10 10 is the worst

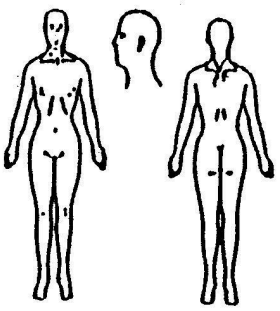
How frequent does it occur?

Daily / Constant / Intermittent AM / PM Better / Worse

_____

CHIEF COMPLAINT #2

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury?

_____

_____

What makes it better/worse?

Better: _____

Worse: _____

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing

Does it travel? Yes / No If yes, where? _____

Any numbness/tingling (in hands or feet)? _____

Out of 10: _____/10

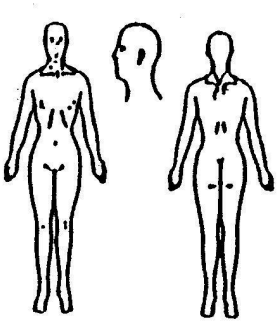
How frequent does it occur?

Daily / Constant / Intermittent AM / PM Better / Worse

_____

CHIEF COMPLAINT #3

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury recent or in the past?

_____

_____

Provokes/Palliates: What makes it better/worse?

Better: _____

Worse: _____

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing

Does it travel? Yes / No If yes, where? _____

Any numbness/tingling (in hands or feet)? _____

Out of 10: _____/10

How frequent does it occur?

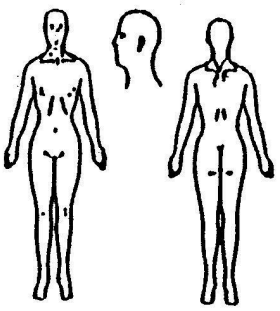
Daily / Constant / Intermittent AM / PM Better / Worse

_____

Any previous chiropractic care? Frequency/duration? _____

CHIEF COMPLAINT #4

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury?

_____

_____

What makes it better/worse?

Better: _____

Worse: _____

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing

Does it travel? Yes / No If yes, where? _____

Any numbness/tingling (in hands or feet)? _____

Out of 10: _____/10

How frequent does it occur?

Daily / Constant / Intermittent AM / PM Better / Worse

_____

YOUR GOALS FOR CARE

How do you want your life to change from chiro care?

What do you love to do?

Are there any things that you haven't been able to fully do that you'd like to get back to doing?

_____

_____

_____

CHIROPRACTIC KNOWLEDGE

What have you heard about chiropractic care? _____

_____

Do you know what a subluxation is? If yes, please describe: _____

_____

Do you practice anything regularly for wellness? _____

_____

PATIENT ATTESTATION

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ Date: _____