BURTIS CHIROPRACTIC CENTER
INTAKE FORM

TODAY'S DATE:_____

First Name: _____ **Middle Name:**_____ **Last Name:**_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Date of Birth: _____/_____/_____ **Social Security #:** _____-_____-_____

Gender: [male] or [female]

MARITAL STATUS: Single / Married / Divorced / Widowed / Other **Maiden Name:**_____

Spouse's Name: _____ Number of Children: _____

I give my consent to appointment reminders by Email / Text Message: YES [ ] NO [ ]

EMERGENCY CONTACT

Name: _____
Relationship: _____
Phone: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Google Search [ ] Referral [ ] Who referred you?_____
Facebook/Instagram [ ] Advertisement [ ]
Drove By [ ] Other [ ] Please specify: _____

EMPLOYMENT (or parent's employment for minors)

Regular Work Status: (*circle one*)
EMPLOYED / PART-TIME EMPLOYED / RETIRED / UNEMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

Employer/School Name: _____
Employer City and State: _____
Occupation: _____ Employer Phone #:_____

PREVIOUS CHIROPRACTIC CARE EXPERIENCE

Have you had previous Chiropractic Care? [YES] or [NO]

If yes, reason for visit: _____ _____
Doctor's name: _____ Date of last chiropractic visit: _____

CURRENT SYMPTOMS

Purpose of visit today: [ ] Wellness [ ] Complaint [ ] Injury [ ] Other

If an injury, where did the injury occur? [ ] Automobile [ ] Work [ ] 3rd Party Premise [ ] Other

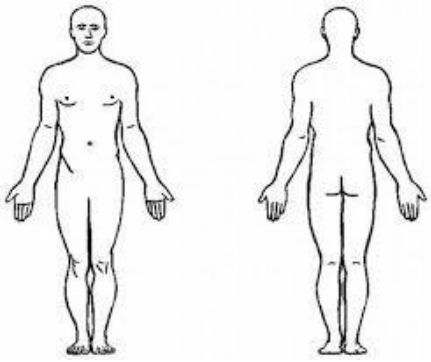
Date of Injury: _____

Details about reason for this visit: _____
_____
_____
_____

Rate your pain on a scale of 1-10: (1 being the least pain and 10 is the maximum pain)

At its best: _____ At its worse: _____ Current level: _____

Please indicate the areas affected:



Describe how the injury, pain, or discomfort originated: _____

_____

_____

_____

In detail, describe the pain/discomfort you are feeling and where: (left or right side, dull vs sharp pain, etc.)

_____

_____

Indicate the areas of your life it has impacted:

[ ] Work [ ] Daily Activities [ ] Sleep [ ] Appetite [ ] Other

Please describe: _____

What date did this concern begin on? _____

Frequency you are experiencing pain from this condition?

[ ] Always [ ] Hourly [ ] Daily [ ] Occasionally

Has this concern:

[ ] Gotten Worse [ ] Stayed Constant [ ] Come and Gone

Have you reduced or limited your work hours because of this condition? [YES] or [NO]

If yes, explain: _____ _____

Have you missed any work due to this injury? [YES] or [NO]

If yes, dates of missed work: _____ TO _____

Is your pain/discomfort worse at certain times of the day? [YES] or [NO]

If yes, when: _____

Does the weather affect your pain/discomfort? [YES] or [NO]

If yes, explain: _____

List anything that aggravates your condition: _____

_____

_____

List anything that relieves or improves your condition: _____

_____

_____

Have you seen any other doctors for this concern? [YES] or [NO]

If yes, Doctor's name: _____

Where: _____

Type of Treatment? _____

X-rays/MRI taken? [YES] or [NO]

Results? [GOOD] [BAD] OR [INDIFFERENCE]

Have you ever had this same condition in the past? [YES] or [NO]

If yes, when: _____

List any other practitioners seen for this injury/condition: _____

_____

If any, what other type of treatment have you received? _____

_____

Were you satisfied with your treatment? [YES] or [NO]

Please list any health conditions that you have been treated for in the last year: (condition, cause, current/resolved)

_____

_____

_____

(*FEMALE ONLY*) Are you pregnant, or have had any signs of pregnancy? [YES] or [NO]

(*FEMALE ONLY*) Are you planning on getting pregnant in the next 12 months? [YES] or [NO]

PERSONAL INCIDENT HISTORY

Broken any bones? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Had any major sprains or strains? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been hospitalized? [YES] or [NO]

Briefly explain: _____

Had surgery? [YES] or [NO]

Briefly explain: _____

Been in an Auto Accident? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been Struck Unconscious? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been diagnosed with an eating disorder? [YES] or [NO]

Briefly explain: _____

Had a stroke? [YES] or [NO]

Briefly explain: _____

FAMILY HEALTH HISTORY

List diagnosed health conditions and untimely deaths of your blood-related family members:

(*Condition and relationship to you*) (ex: arthritis, cancer, diabetes, heart disease, high blood pressure)

_____

_____

CHILDREN ONLY:

Please list any health conditions treated for since birth: (condition, cause, current/resolved): _____

_____

Please list any complications during pregnancy/delivery: _____

_____

CHILD HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

[ ] ADD / ADHD	[ ] Bronchitis	[ ] Frequent Urination	[ ] Other:_____
[ ] Allergies	[ ] constipation	[ ] Growing Pain	_____
[ ] Asthma	[ ] Diarrhea	[ ] Headaches	_____
[ ] Bedwetting	[ ] Ear Infection	[ ] Sleep Problems	_____

SOCIAL HISTORY AND LIFE CHOICES

Alcohol:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Diet Food Products:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Energy Products & Over-the-Counter Stimulants:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Caffeine Drinks & Products:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Soft Drinks:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Water:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Fresh & Homemade Foods:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Preprocessed, Packaged, & Restaurant Food:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Exercise:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Tobacco:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Drugs/Medications:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never

Please list medications: _____

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

[ ] Allergies
[ ] Alcoholism
[ ] Anemia
[ ] Arteriosclerosis
[ ] Arthritis
[ ] Asthma
[ ] Autoimmune Disease
[ ] Back Pain
[ ] Bleeding Disorders
[ ] Breast Lump
[ ] Bronchitis
[ ] Bruise Easily
[ ] Cancer
[ ] Cataracts
[ ] Chest Pain
[ ] CHF (congestive heart disease)
[ ] Cold Extremities
[ ] Constipation
[ ] COPD/emphysema
[ ] CVA (stroke/TIA)
[ ] Cramps
[ ] Dementia/Alzheimer's
[ ] Depression
[ ] Diabetes
[ ] Digestion Problems
[ ] Diagnosed emotional/ mental disorders
[ ] Dizziness
[ ] Epilepsy
[ ] Excessive Menstruation
[ ] Eye Pain or Difficulties
[ ] Fatigue
[ ] Frequent Urination
[ ] Gallbladder disease/ stones
[ ] Glaucoma
[ ] Gout
[ ] Headache
[ ] Hemorrhoids
[ ] High Blood Pressure
[ ] Hot Flashes
[ ] Irregular Heart Beat
[ ] Irregular Menstrual Cycle
[ ] Kidney Infection
[ ] Kidney Stones
[ ] Liver disease/cirrhosis
[ ] Loss of Memory
[ ] Loss of Balance
[ ] Loss of Smell
[ ] Loss of Taste
[ ] Lung disease
[ ] Macular Degeneration
[ ] Migraines
[ ] Nosebleeds
[ ] Pacemaker
[ ] Parkinson's
[ ] Polio
[ ] Poor Posture
[ ] Prostate Trouble
[ ] Retinal Disease
[ ] Sciatica
[ ] Seizures
[ ] Shortness of Breath
[ ] Sinus Infection
[ ] Sleep Problems/Insomnia
[ ] Skin Sensitivity
[ ] Spinal Curvatures
[ ] Stroke
[ ] Swelling of Ankles
[ ] Swollen Joints
[ ] Thyroid Condition
[ ] Tuberculosis
[ ] Ulcers
[ ] Varicose Veins
[ ] Venereal Disease(STD)
[ ] Other:
_____
_____
_____

AUTHORIZATION

I certify that I'm the patient or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for payment in full for all services unless other arrangements have been made with the business manager. If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any expense incurred in collecting my account. If my bill becomes delinquent and you have to employ an outside agent to collect the bill, all collection expenses will become my responsibility. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me.

☐ I agree with this statement of authorization.

If signing for your child:

☐ I hereby, authorize Dr. Scott Burtis to administer treatment as he so deems necessary, even in the absence of a legal guardian to my child. (In cases where another family member/friend might bring the patient into our office.)

Name of Patient (Please Print): _____

Patient's/Guardian's Signature: _____ Date: _____