Circle Chiropractic
Joseph F. Arme, D.C.
Ben Duke, D.C.
3123 Southgate Circle
Sarasota, FL 34239
P: 941.366.0203
F: 941.366.0204
www.circlesrq.com

New Patient Intake Form

Date: _____

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

Birthdate: _____ **Social Security Number:** _____ **Height:** _____ **Weight:** _____

Address: _____

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

Phone – Mobile: _____ **Home:** _____ **Work:** _____

Email: _____

Employer: _____ **Occupation:** _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Spouse's Name: _____ **Children:** _____

How did you hear about us? ◯ Referral ◯ Walk-in ◯ Phone Book ◯ Website ◯ Other: _____

Referred by: ◯ Family ◯ Friend ◯ Physician ◯ Other Name: _____

Dominance: ◯ Right-Handed ◯ Left-Handed ◯ Ambidextrous

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Have you consulted a chiropractor before? ◯ Yes ◯ No If yes, whom? _____

CURRENT CONDITION

Complaints: (list your complaints in order of severity)

1.	2.
3.	4.

Do you have a prior history of the complaint(s) listed? ◯ Yes ◯ No

If yes, please describe: _____

How long have you been experiencing symptoms? _____

Do you know what caused the problem(s)? _____

Since your symptoms started, has your condition: ◯ Gotten better ◯ Gotten worse ◯ Stayed the same

Rate your pain on a scale of 0—10, with 0 being no pain at all and 10 being the worst pain imaginable:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Quality: Describe your pain. ◯ Aching ◯ Burning ◯ Cramping ◯ Deep ◯ Dull ◯ Numb ◯ Radiating ◯ Sharp ◯ Shooting ◯ Sore ◯ Stabbing ◯ Stiff ◯ Swelling ◯ Tight ◯ Tingling ◯ Throbbing ◯ Other: _____

What treatment(s) have you tried for your condition(s)? ◯ None ◯ Acupuncture ◯ Anti-inflammatories ◯ Bracing ◯ Chiropractic Care ◯ Elevation ◯ Exercise ◯ Heat ◯ Ice ◯ Massage ◯ Movement ◯ Pain medication ◯ Physical therapy ◯ Rest ◯ Stretching ◯ Surgery ◯ Walking ◯ Wraps ◯ Other: _____

Did any of the above provide relief? ◯ No ◯ Yes (Please explain): _____

What daily activities are affected due to the problem(s)? ◯ None ◯ Bathing ◯ Caring for children ◯ Climbing stairs ◯ Cleaning ◯ Cooking ◯ Doing laundry ◯ Dressing ◯ Driving ◯ Eating ◯ Exercising ◯ Grooming ◯ Going from lying to sitting ◯ Going from sitting to standing ◯ Housework ◯ Lying down ◯ Lifting ◯ Oral care ◯ Sex ◯ Shopping ◯ Sitting ◯ Standing ◯ Sleeping ◯ Social/recreational activities ◯ Stretching ◯ Toileting ◯ Using technology ◯ Walking ◯ Working ◯ Yard work

Have you been given a diagnosis for your condition(s)? ◯ No ◯ Yes: _____

Does the pain travel to any other areas? Please explain: _____

Do you notice the pain during a certain time of day? _____

How frequently do you experience symptoms? _____ times per ◯ Day ◯ Week ◯ Month ◯ Year

How long do your symptoms last? _____ ◯ Minutes ◯ Hours

Aggravating Factors: What makes the problem worse? ◯ Nothing ◯ Most movements ◯ Bending ◯ Carrying things ◯ Coughing ◯ Driving ◯ Eating ◯ Exercise ◯ Going up/down stairs ◯ Going from lying to sitting ◯ Going from lying to standing ◯ Going from sitting to standing ◯ Heat ◯ Housework ◯ Ice ◯ Jogging ◯ Lifting ◯ Lying down ◯ Massage ◯ Pulling ◯ Pushing ◯ Running ◯ Sitting ◯ Sleeping ◯ Sneezing ◯ Squatting ◯ Standing ◯ Prolonged standing ◯ Stress ◯ Stretching ◯ Taking a deep breath ◯ Turning ◯ Twisting ◯ Walking ◯ Working

HEALTH HISTORY

Surgeries:

Date of Surgery	Description

Date of Surgery	Description

Traumas:

Date of Incident	Description	Injuries Sustained	Treatment Received

Allergies:

Medications/Vitamins/Supplements:

Conditions:

Have | Had			
◯ | ◯ AIDS/HIV	◯ | ◯ Emphysema	◯ | ◯ Miscarriage	◯ | ◯ Thyroid Problems
◯ | ◯ Anemia	◯ | ◯ Epilepsy	◯ | ◯ Multiple Sclerosis	◯ | ◯ Tuberculosis
◯ | ◯ Arthritis	◯ | ◯ Fibromyalgia	◯ | ◯ Osteoporosis	◯ | ◯ Tumors/Growths
◯ | ◯ Asthma	◯ | ◯ Fractures	◯ | ◯ Pacemaker	◯ | ◯ Prostate Problems
◯ | ◯ Bleeding Disorder	◯ | ◯ Gallstones	◯ | ◯ Parkinson's Disease	◯ | ◯ Prosthesis
◯ | ◯ Breast Lump	◯ | ◯ Glaucoma	◯ | ◯ Pinched Nerve	◯ | ◯ Psychiatric Disorder
◯ | ◯ Bronchitis	◯ | ◯ Gout	◯ | ◯ Immune Deficiency	◯ | ◯ Rheumatoid Arthritis
◯ | ◯ Cancer	◯ | ◯ Heart Disease	◯ | ◯ Kidney Disease	◯ | ◯ Ulcers
◯ | ◯ Chemical Dependency	◯ | ◯ Hepatitis	◯ | ◯ Liver Disease	◯ | ◯ Vaginal Infections
◯ | ◯ Chicken Pox	◯ | ◯ Hernia	◯ | ◯ Migraine Headaches	◯ | ◯ Venereal Disease
◯ | ◯ Chronic Fatigue	◯ | ◯ Herniated Disc	◯ | ◯ Seizures	◯ | ◯ Whooping Cough
◯ | ◯ Depression	◯ | ◯ High Blood Pressure	◯ | ◯ Stroke	
◯ | ◯ Diabetes	◯ | ◯ High Cholesterol	◯ | ◯ Suicide Attempt	
◯ | ◯ Other: _____			

Are you currently being treated for any of the conditions listed above? ◯ Yes ◯ No

If yes, please explain: _____

Is there any history in your family for any of the above conditions? ◯ Yes ◯ No

If yes, please indicate the family member(s) and their condition(s): _____

_____

Are you presently under the care of a health care provider? ◯ Yes ◯ No

If yes, please list your physician(s): _____

If yes, please list your condition(s):_____

Date of your last physical exam: _____ By whom? _____

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic ◯ Other: _____

Sleep: ◯ Trouble falling asleep ◯ Trouble staying asleep ◯ Restful ◯ Other: _____

Stress: ◯ None ◯ Low ◯ Moderate ◯ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? _____

DAILY HABITS

Do you smoke? ◯ Never Smoked ◯ Current daily smoker ◯ Current occasional smoker ◯ Former smoker

How many packs per day? _____ For how many years? _____ When did you quit? _____

Caffeinated beverages: ◯ None ◯ 1 to 5 ◯ 6 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ Over 20 **Per:** ◯ Day ◯ Week ◯ Month

Alcoholic beverages: ◯ None ◯ 1 to 5 ◯ 6 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ Over 20 **Per:** ◯ Day ◯ Week ◯ Month

Do you exercise regularly? ◯ No ◯ Light ◯ Moderate ◯ Heavy Times per week: _____

REVIEW OF SYSTEMS

Musculoskeletal: Please check all that apply. ◯ None

Have | Had			
◯ | ◯ Arm/hand pain	◯ | ◯ Foot/leg pain	◯ | ◯ Hip pain	◯ | ◯ Knee pain
◯ | ◯ Low back pain	◯ | ◯ Mid back pain	◯ | ◯ Upper back pain	◯ | ◯ Neck pain
◯ | ◯ Muscle or joint pain	◯ | ◯ Swelling of joints	◯ | ◯ Shoulder(s) pain	◯ | ◯ Stiffness
◯ | ◯ Other: _____			

Cardiovascular/Respiratory: Please check all that apply. ◯ None

Have | Had		
◯ | ◯ Chest pain/pressure/discomfort	◯ | ◯ Cold hands/feet	◯ | ◯ Persistent coughing
◯ | ◯ Hemoptysis (coughing up blood)	◯ | ◯ Coughing up phlegm	◯ | ◯ Wheezing
◯ | ◯ Dizziness/lightheadedness	◯ | ◯ Fainting	◯ | ◯ Irregular heartbeat
◯ | ◯ Palpitations	◯ | ◯ Edema (swelling)	◯ | ◯ Tightness in chest
◯ | ◯ Shortness of breath	◯ | ◯ Paroxysmal nocturnal dyspnea (sudden awakening with a shortness of breath)	
◯ | ◯ Other: _____		

Head/Neck: Please check all that apply. ◯ None

Have | Had			
◯ | ◯ Dizziness	◯ | ◯ Facial pain	◯ | ◯ Headache	◯ | ◯ Migraines
◯ | ◯ Head injury	◯ | ◯ Lumps	◯ | ◯ Neck Pain	◯ | ◯ Stiffness
◯ | ◯ Other: _____			

Eyes: Please check all that apply. ◯ None

Have | Had			
◯ | ◯ Blurred vision	◯ | ◯ Burning	◯ | ◯ Cataracts	◯ | ◯ Double vision
◯ | ◯ Dryness	◯ | ◯ Flashing lights	◯ | ◯ Glasses/contacts	◯ | ◯ Glaucoma
◯ | ◯ Itching	◯ | ◯ Pain	◯ | ◯ Redness	◯ | ◯ Specks
◯ | ◯ Vision problems	◯ | ◯ Aura	◯ | ◯ Other: _____	

Ears: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Buzzing in ears	◯ | ◯ Decreased hearing	◯ | ◯ Drainage	◯ | ◯ Earache
◯ | ◯ Ear infections	◯ | ◯ Poor balance	◯ | ◯ Poor hearing	◯ | ◯ Tinnitus (ringing in ears)
◯ | ◯ Vertigo	◯ | ◯ Other: _____		

Nose: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Allergies	◯ | ◯ Blocked sinuses	◯ | ◯ Discharge	◯ | ◯ Excessive mucus
◯ | ◯ Hay fever	◯ | ◯ Itching	◯ | ◯ Nose bleeds	◯ | ◯ Sinus pressure/pain
◯ | ◯ Stuffiness/blockage	◯ | ◯ Other: _____		

Throat/Mouth: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Bleeding	◯ | ◯ Blue lips	◯ | ◯ Braces	◯ | ◯ Dentures
◯ | ◯ Difficulty swallowing	◯ | ◯ Dry mouth	◯ | ◯ Hoarseness	◯ | ◯ Mouth pain
◯ | ◯ Redness	◯ | ◯ Sore Throat	◯ | ◯ Sores on lips or tongue	◯ | ◯ Clicking jaw
◯ | ◯ Swollen glands	◯ | ◯ Thrush	◯ | ◯ Tooth pain	◯ | ◯ Grinding teeth
◯ | ◯ Other: _____			

Urinary: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had
◯ | ◯ Burning or pain with urination	◯ | ◯ Difficulty urinating	◯ | ◯ Hematuria (blood in urine)
◯ | ◯ Frequent urination	◯ | ◯ Frequent urinary tract infections	◯ | ◯ Urgency
◯ | ◯ Unable to hold urine (incontinence)	◯ | ◯ Kidney infections	◯ | ◯ Kidney stones
◯ | ◯ Up at night to urinate	◯ | ◯ Water retention	
◯ | ◯ Other: _____		

Gastrointestinal: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Change in appetite	◯ | ◯ Change in bowel habits	◯ | ◯ Constipation	◯ | ◯ Diarrhea
◯ | ◯ Heartburn	◯ | ◯ Nausea	◯ | ◯ Rectal bleeding	◯ | ◯ Jaundice (yellow eyes/skin)
◯ | ◯ Swallowing difficulty	◯ | ◯ Other: _____		

Endocrine: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Change in appetite	◯ | ◯ Cold intolerance	◯ | ◯ Dry skin	◯ | ◯ Excessive thirst
◯ | ◯ Heat intolerance	◯ | ◯ Sweating	◯ | ◯ Other: _____	

Vascular/Hematologic: Please check all that apply. ◯ None

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Cold hands and/or feet	◯ | ◯ Ease of bleeding	◯ | ◯ Ease of bruising	◯ | ◯ Leg cramping
◯ | ◯ Claudication (calf pain with walking)		◯ | ◯ Other: _____	

Neurologic: Please check all that apply. ◯ None

Have | Had		Have | Had		Have | Had		Have | Had	
◯ | ◯	Dizziness	◯ | ◯	Fainting	◯ | ◯	Memory confusion	◯ | ◯	Neuralgia
◯ | ◯	Numbness	◯ | ◯	Poor concentration	◯ | ◯	Seizures	◯ | ◯	Tingling
◯ | ◯	Tremors	◯ | ◯	Weakness	◯ | ◯	Other: _____		

Psychiatric: Please check all that apply. ◯ None

Have | Had		Have | Had		Have | Had		Have | Had	
◯ | ◯	Anxiety	◯ | ◯	Depression	◯ | ◯	Easily angered/irritated	◯ | ◯	Memory loss
◯ | ◯	Nervousness	◯ | ◯	Stress	◯ | ◯	Suicidal thoughts	◯ | ◯	Frequent crying
◯ | ◯	Other: _____						

Female:

Are you pregnant: ◯ Yes ◯ No Date of last period: _____ Number of days between periods: _____

Age menstruation began: _____ Age menstruation stopped: _____

Number of pregnancies: _____ Number of natural deliveries: _____ Number of Cesareans: _____

Please check all that apply. ◯ None

Have | Had		Have | Had		Have | Had		Have | Had	
◯ | ◯	Clotting	◯ | ◯	Discharge	◯ | ◯	Food cravings	◯ | ◯	Heavy bleeding
◯ | ◯	Hot flashes	◯ | ◯	Infections	◯ | ◯	Irregular periods	◯ | ◯	Itching or rash
◯ | ◯	Leg cramps	◯ | ◯	Light bleeding	◯ | ◯	Little/no sex drive	◯ | ◯	Menstrual pain/cramps
◯ | ◯	Missed periods	◯ | ◯	Mood swings	◯ | ◯	Painful breasts	◯ | ◯	Pain with sex
◯ | ◯	STD's	◯ | ◯	Vaginal dryness	◯ | ◯	Vaginal sores	◯ | ◯	Water retention
◯ | ◯	Other: _____						

Male: Please check all that apply. ◯ None

Have | Had		Have | Had		Have | Had		Have | Had	
◯ | ◯	Discharge	◯ | ◯	Erectile dysfunction	◯ | ◯	Hernia	◯ | ◯	Impotence
◯ | ◯	Low sex drive	◯ | ◯	Masses or pain	◯ | ◯	Pain with sex	◯ | ◯	Painful discharge
◯ | ◯	Prostate problems	◯ | ◯	Sores	◯ | ◯	STD's		
◯ | ◯	Other: _____						

PERSONAL HEALTH INFORMATION

Please list the names and relationships of people to whom you authorize the practice to release personal health information:

_____ _____

_____ _____

_____ _____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement carefully and initial your agreement.

_____ Initials I instruct the chiropractor to deliver the care that, in his or her professional judgement, can help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

_____ Initials I authorize the doctor to personally discuss with me products that may benefit my health and/or condition.

_____ Initials I was provided a copy of the Notice of Privacy Practices and I have either read and understand them or declined the opportunity to read them. I understand that I may request a copy of the Privacy Policy and that this form will be placed in my patient chart and maintained for six years.

_____ Initials I grant permission to be called to confirm or reschedule an appointment, and to be sent occasional cards, letters, emails, or health information as an extension of my care in this office. You have my permission to contact me in the following ways (**select all that apply**):

◯ Mail ◯ Phone/Voicemail: _____ ◯ Email: _____

_____ Initials I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for the payment of any covered or non-covered services I receive.

_____ Initials To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____

Print Name of Patient

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date