GONSTEAD
FAMILY CHIROPRACTIC

New Patient Intake - PI

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name: _____ **Date:** ____/____/____ **Sex:** ☐Female ☐Male
First MI Last

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

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

Birth Date: ____/____/____ **Height:** _____ **Weight:** _____ **e-mail address:** _____

Your Employer: _____ **Occupation:** _____

Spouse/ Parent's Name: _____ **Status:** ☐Minor ☐Married ☐Single ☐Other

Names and Ages of Children: _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency: _____ **Phone:** _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Gonstead Family Chiropractic can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

Have you ever been diagnosed with a Subluxation? ☐No ☐Yes, When? _____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ☐Yes ☐No Name of D.C. _____

How long under care? ☐_____Days ☐_____Years Date of last visit: _____

Why did you stop care?_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath
☐ Massage Therapist ☐ Psychotherapist ☐ Energy Healer ☐ Dentist

Reason:_____

_____

Patient Signature: _____ **Today's Date:** ____/____/____

FOR WOMEN

Are you pregnant? ☐Yes ☐No Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: _____ Date: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife: _____

Auto Accident Information and Explaination

INSURANCE INFORMATION

INSURANCE CO: _____ **Policy #:** _____

Name on Policy (if not self) _____

Responsible Party's Name: _____ **Agent's name** _____

Address: _____

ATTORNEY: _____ **Phone:** _____

Address: _____

NATURE OF ACCIDENT

Date of accident: ____/____/____ **Time of Day:** _____ **Location of accident:** _____

Relative speed of you car: _____ (mph) **Relative speed of the other car** _____(mph)

What was the site of impact on your car?

☐Behind ☐Front

☐Driver's Side ☐Passenger's Side

Where were you sitting at the time of impact?

☐Driver

☐Passenger .... ☐Front ☐Back

Were you wearing your seat belt?... ☐Yes ☐No

Were your brakes applied?..... ☐Yes ☐No

Did your airbags deploy? ☐Yes ☐No

Did your seat back break? ☐Yes ☐No

PLEASE DESCRIBE THE ACCIDENT

(in your own words): _____

_____

_____

Your Vehicle Type: _____ **Other Vehicle Type:** _____

List any parts of your body that struck the following vehicle parts during the accident:

Dashboard: _____ Door: _____

Windshield: _____ Door Window: _____

Steering Wheel: _____ Other: _____

Did you lose consciousness? ☐Yes ☐No for how long? _____

ADDITIONAL INFORMATION:

What was your mental and emotional state immediately following the accident? _____

Were the police notified? ☐Yes ☐No **Did you receive medical attention at the scene of the accident?** ☐Yes ☐No

Where did you go immediately following the accident? _____

Have you been treated by another doctor since the accident? ☐Yes No If yes...

Please list the name of the doctor/hospital and address: _____

Were you given: ☐MRI ☐x-ray ☐CT scan ☐Surgery ☐Bloodwork ☐Medication ☐Recommendations

Please explain what type of treatment you received: _____

Do you have any congenital (from birth) factors that may relate to this problem? ☐Yes ☐No, _____

Do you have any previous illnesses which relate to this case? ☐Yes, _____

Have you ever been involved in an accident before? ☐Yes ☐No

If yes, explain: _____

Have you lost time from work as a result of this accident? ☐Yes ☐No

If yes... Last day worked: ____/____/____ Type of employment: _____

PLEASE DESCRIBE HOW YOU FELT

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Please add any other information that you feel is pertinent:

_____

_____

Health, Wellness & Chiropratic Care

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT: (chief complaint)

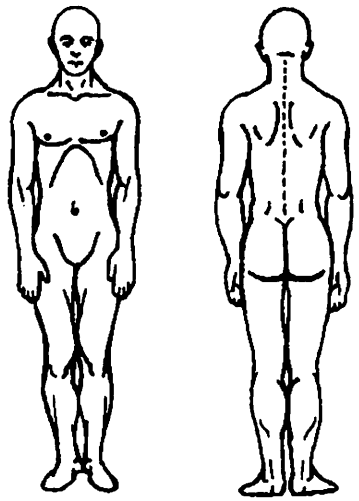
1) _____ 2) _____ 3) _____ 4) _____

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

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other	= ***



How often do you notice your symptoms? ☐Constantly ☐Frequently ☐Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Please describe any other activities that are restricted due to this injury? _____

_____

When did you first notice these symptoms? _____ **Is the condition getting worse?** ☐No ☐Yes

Have you had this problem before? ☐No ☐Yes, When?_____

Have you had an injury or fall? ☐No ☐Yes, Describe_____

Have you had x-rays before? ☐No ☐Yes, When? _____ What areas? _____

I am currently taking the following medications/supplements for the following reasons: ☐None

_____

_____

Surgical History: _____ ☐None

Do you currently have or have you previously had any of the following symptoms:

☐Nervousness	☐Irritability	☐Sleep Problems	☐Allergies	☐Dizziness	☐Headaches
☐Fatigue	☐Depression	☐Anxiety	☐Menstrual Pain	☐Hot Flashes	☐Heartburn
☐Tension	☐Mood Swings	☐Ringing in Ears	☐Menstrual Irregularity	☐Constipation	☐Urinary Problems

QUALITY OF LIFE (presently)

How do you grade your physical health?	☐Good	☐Fair	☐Poor
How do you grade your emotional/mental health?	☐Good	☐Fair	☐Poor
How do you rate your overall "quality of life"?	☐Good	☐Fair	☐Poor

Do you exercise regularly? If yes, how often? _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

☐Relief of a symptom only ☐Relief and Prevention of a symptom or problem ☐Healthier spine and nerve system

☐Optimal health on all levels ☐OTHER_____

Health, Wellness & Chiropratic Care

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION and results in nerve malfunction .
Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.
The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to, how they may relate to your present spinal, nerve and health status and whether they have caused **Vertebral Subluxations.**

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

☐Home ☐Natural ☐Hospital ☐Caesarian section ☐Forceps
☐Breech ☐Cord around neck ☐Prolonged labor ☐Drug induced labor ☐Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (Check all that apply)

☐Automobile ☐Motorcycle ☐Bicycle ☐Sports ☐Playground ☐Abuse

If yes, state type of injury and date: _____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)**?** ☐Yes ☐No - If yes, list body parts: _____

_____

Have you ever been hospitalized or had surgery? ☐Yes ☐No

If yes, state reason and dates: _____

How often do you get outside activity/exercise? What types? _____

Do you sit more than 3 hours a day? ☐Yes ☐No - If yes, how many? _____hours/day Hours of TV a day? _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	☐Yes	☐No	Loss of Loved One	☐Yes	☐No	Abuse	☐Yes	☐No
Work or School	☐Yes	☐No	Divorce/Separation	☐Yes	☐No	Financial	☐Yes	☐No
Lifestyle Change	☐Yes	☐No	Parents Divorce	☐Yes	☐No	Illness	☐Yes	☐No

On a scale of zero to ten, rate the amount of STRESS in your LIFE.

0 1 2 3 4 5 6 7 8 9 10
None to Little STRESSED to MAX

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ☐Yes ☐No If yes, did you have a reaction? ☐Yes ☐No ☐Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

☐Toxic chemicals ☐Second hand smoke ☐Drug therapy
☐Radiation ☐Chemotherapy ☐Other: _____

If yes, please list: _____

Do you have allergies or sensitivities to any foods? ☐Yes ☐No If yes, please list: _____

_____

Do you <u>presently</u> consume any of the following?

☐Coffee/Caffeine ☐Alcohol ☐Tobacco ☐Over the counter drugs ☐Prescribed drugs ☐Sugar

Please list all medications (prescribed <u>and</u> over the counter):_____

_____

Thank you for choosing Gonstead Family Chiropractic. We look forward to serving you.