GONSTEAD FAMILY CHIROPRACTIC

# New Patient Intake

## PATIENT INFORMATION

**CONFIDENTIAL**

*Thank you for the opportunity to serve you and your family. If you have any questions, DO NOT hesitate to ask. Our whole team is here to help.*

**Name:** _____ **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:** _____

**How did you hear about our office or is there someone we can thank for referring you to us?** _____

_____

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

## REASON FOR SEEKING CHIROPRACTIC CARE

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

_____

_____

**When did the condition(s) first begin?** _____

**This condition is:** ☐ Getting worse ☐ Improving ☐ Staying the same ☐ Intermittent ☐ Constant ☐ Unsure

**How did this problem start?** ☐ Suddenly ☐ Gradually ☐ Post-Injury ☐ A Slip or Fall

**Have you had this problem before, and when?** _____

**Are these concerns affecting your quality of life?** (Please circle all that apply and if yes, please explain in what ways)

Work: N Y _____ Sleep: N Y _____

School: N Y _____ Sitting: N Y _____

Exercise/walking: N Y _____ Love life: N Y _____

Standing: N Y _____ Bending: N Y _____

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

_____

**What makes the problem better?** _____

**What makes the problem worse?** _____

**Please name any other health professionals and their specialty that you are also receiving care from:**

_____

**Do you follow a special dietary regime?** _____

**Do you currently have or have you previously had any of the following health concerns?** (write C = current or P = previously)

| | | | |
|---|---|---|---|
| __ Anxiety | __ Nervousness | __ Depression | __ Ringing in Ears |
| __ Fatigue | __ Sleep Problems | __ Digestive Troubles | __ Nausea/Vomiting |
| __ Diabetes | __ Constipation | __ Sensitivity to Light | __ Loss of Concentration |
| __ Memory Problems | __ Loss of Balance | __ Menstrual Pain | __ Menstrual Irregularity |
| __ Mood Changes | __ Dizziness/Vertigo | __ Hot Flashes | __ Hypertension |
| __ Arthritis | __ Headaches | __ Neck/Back Pain | __ Stiffness |
| __ Pain in Arms | __ Pain in Legs | __ Allergies | __ Sinus Troubles |
| __ Irritability | __ Cold Hands/Feet | __ Lack of Flexibility | |

__ Other: _____

## HEALTH CARE HISTORY

**Have you ever received Chiropractic care?** ☐Yes ☐No Name of D.C. (if known) _____

How long under care & for what? _____ Date of last visit: ___/___/_____

Why did you stop care? _____

**Do you regularly consult any of the following providers?** (check all that apply)

☐ MD ☐ Naturopath ☐ Acupuncturist ☐ Homeopath ☐ Massage Therapist ☐ Psychotherapist ☐ Energy Healer ☐ Dentist

Reason(s):_____

_____

**How do you grade your physical health?** ☐ Good ☐ Fair ☐ Poor ☐ Improving

**Surgical History:** _____

**List any significant falls or other injuries as an adult:** _____

**List any notable childhood injuries:** _____

**List any auto accidents:** _____

**Youth or college sports played:** _____

**Exercise frequency:** ☐ None ☐ 1-2x per week ☐ 3-5x per week ☐ Daily

**Normal sleep posture:** ☐ Back ☐ Left side ☐ Right side ☐ Stomach **Do you wake up:** ☐ Refreshed & ready ☐ Stiff & tired

**How many combined hours per day you typically spend sitting at a desk or on a computer, tablet or phone?** _____

**List any problems with flexibility** (like putting on socks/shoes, etc.): _____

**Medications:** ☐ Anxiety/Depression ☐ ADD/ADHD ☐ Blood Pressure ☐ Cholesterol ☐ Diabetes
☐ Migraine/Headache ☐ NSAIDS ☐ Muscle Relaxers ☐ Pain Narcotics ☐ Acetaminophen

Other: _____

**Vitamins / Supplements:**

☐ Fish Oil/Omega-3 ☐ Multivitamin ☐ Probiotics ☐ Magnesium ☐ Calcium ☐ Potassium ☐ Vitamin C ☐ Vitamin D3

Other: _____

**Do you have allergies or sensitivities to any foods?** N Y If yes, please list: _____

**Do you presently consume any of the following?** ☐Coffee/Caffeine ☐ Water ☐ Soda ☐ Fruit Juices ☐ Gatorade ☐ Alcohol
☐ Tobacco ☐ Fast Food ☐ Dairy ☐ Sugar ☐ Gluten ☐ Artificial Sweeteners ☐ Cigarettes/Cigar ☐ Rec Drugs

**Do you follow a special dietary regime?** _____

**How do you grade your emotional/mental health?** ☐ Good ☐ Fair ☐ Poor ☐ Improving

**On a scale of zero to ten, rate the amount of STRESS in your life:** 1 2 3 4 5 6 7 8 9 10

**Rate your STRESS for each:**

| | None | | | Moderate | High | | None | | | Moderate | High | | None | | | Moderate | High |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Home: | 1 | 2 | 3 | 4 | 5 | Money: | 1 | 2 | 3 | 4 | 5 | Work: | 1 | 2 | 3 | 4 | 5 |
| Life: | 1 | 2 | 3 | 4 | 5 | Health: | 1 | 2 | 3 | 4 | 5 | Family: | 1 | 2 | 3 | 4 | 5 |

**How do you rate your overall "quality of life"?** ☐ Good ☐ Fair ☐ Poor ☐ Improving

**How high of a priority are you to yourself and your health?** (circle one) 1 2 3 4 5 6 7 8 9 10

Explain: _____

**What health goal, if you were to complete it, would have the greatest impact on your life?** _____

_____

## Your Expectations from Gonstead 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_____

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**Acknowledgement of information:**

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

## *For Women

**Are you pregnant?** ☐Yes ☐No Date of last monthly cycle: ___/___/_____

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: _____