SouthWest CHIROPRACTIC

Please bring this completed paperwork to your first appointment, or email it to: info@swchealthcenter.com
800 Prairie Center Dr, Suite 200 • Eden Prairie, MN 55344 • P: (952) 943-1188 • F: (952) 943-1177

Welcome to SouthWest Chiropractic and we thank you for trusting us with your healthcare needs. These questions allow our providers and front office staff to best serve you. We ask that you please fill them all out to the best of your ability. If you have questions or need clarification please consult our front desk staff.

How did you hear about our office? _____
(Google, Yelp, Insurance Provider Website, Friend/Family Member, Other Medical Professional, Other.)

What is your preferred language? _____ Do you need an interpreter for your visit? Y ◯ N ◯

Patient name:_____ Date of Birth:_____-_____-_____ Sex: M ◯ F ◯

Home/Cell phone:_____(Carrier:_____)
Email:_____

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

Are you the primary policyholder for insurance being used? Y ◯ N ◯ If no, please provide primary's full name and D.O.B:

Name:_____ Date of Birth:_____-_____-_____

Occupation:_____ Employer:_____

Emergency contact:_____ Phone:_____

Primary Care Physician/Clinic:_____ If necessary, may we contact them? Y ◯
N ◯

Please complete this section concerning personal demographics: Race/Ethnicity

Asian ☐ Black/African-American ☐ Caucasian ☐ Hispanic ☐ Latino ☐ Native American ☐

Pacific Islander ☐ More than 1 Race/Ethnicity:_____

How do you currently rank your overall health right now?

Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor ◯

I am interested in the following types of treatment:
Chiropractic care ☐ Exercise rehabilitation ☐ Acupuncture ☐ Pulsed Electromagnetic Field Therapy ☐

High Intensity Laser Therapy ☐ Nutritional Advice/Supplementation ☐ Massage Therapy ☐

What are your primary job or home tasks?
Computer work ☐ Lifting, carrying ☐ Prolonged sitting ☐ Pushing, pulling ☐ Driving ☐

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Operating a machine, assembly ☐ Prolonged standing ☐ Repetitive tasks ☐

Other:_____

What are you being seen for today?_____

When did this problem begin?_____

How did this problem occur?_____

What is your pain level today:

No Pain 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ ***Worst pain***

Please circle/mark all that apply to your current or past medical history:

☐ Abdominal pulsating mass	☐ Asthma	☐ Anemia	☐ Calf pain/swelling or warmth
☐ Changes in bowel/bladder	☐ Cancer	☐ Chest pain	☐ Chemical dependency
☐ Concussion/Dizziness	☐ Changes in skin color	☐ Currently pregnant	☐ Depression
☐ Emphysema	☐ Fibromyalgia	☐ Foot drop	☐ Heart problems
☐ Hepatitis	☐ High blood pressure	☐ History of fx	☐ Incontinence
☐ Implanted device	☐ Kidney disease	☐ Menopause	☐ Mental illness
☐ Migraines/headaches	☐ Multiple Sclerosis	☐ Numbness/tingling	☐ Saddle anesthesia
☐ Non-healing wounds	☐ Osteoarthritis	☐ Osteoporosis	☐ Anxiety
☐ Pain at night/rest	☐ Persistent fever/chills	☐ Rheumatoid arthritis	☐ Seizures
☐ Progressive neurological deficits	☐ Severe Dizziness	☐ Severe Headache	☐ Significant weakness
☐ Sleep disorder/apnea	☐ Smoking	☐ Stroke	☐ Tuberculosis
☐ Unexplained weight loss	☐ Extremity weakness	☐ Thyroid problems	☐ Bleeding disorders
☐ Atrial fibrillation	☐ History of blood clots	☐ Diabetes	☐ Excessive thirst
☐ Nausea/vomiting	☐ Shortness of breath	☐ Cough	☐ Easy bruising
☐ Blurred vision	☐ Double vision	☐ Loss of taste/smell	☐ Memory loss

☐ Other:_____

Medical Allergies: Latex ☐ Adhesive ☐ Other:_____

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Drugs/Medications currently taking:

_____

_____

_____

Supplements currently taking & Reason for use:

_____

_____

Mark all that apply to your immediate family history: M=mother, F=father, B=brother, S=sister):

Colon Cancer	Heart Disease	Bleeding Problems
Breast Cancer	Mental Illness	Alcohol Abuse
Prostate Cancer	High Cholesterol	Hepatitis
Other Cancer:_____	Autoimmune disease	Osteoporosis
Obesity	Seizure Disorders	Liver Disease
Diabetes	Colon Polyps	Arthritis
High Blood Pressure	Colitis	Kidney Disease

Trauma/Surgical History: Please specify if you have ever had or been involved in:

Motor vehicle collision….Y ◯ N ◯	Sports injury……...Y ◯ N ◯
Significant fall(s).....Y ◯ N ◯	Exercise induced injury….Y ◯ N ◯
Work injury……...Y ◯ N ◯	Physical Abuse……...Y ◯ N ◯
Surgeries……...Y ◯ N ◯	Other physical trauma…...Y ◯ N ◯

Explain relative dates and types of injuries/surgeries::

_____

_____

_____

Social History:

Do you use tobacco products….Y ◯ N ◯ If yes, please describe what type and duration of use:_____

Have you tried to quit tobacco use….Y ◯ N ◯ Would you like help?..Y ◯ N ◯

Do you use recreational drugs….Y ◯ N ◯ If yes, please note substance(s):_____

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Do you drink alcohol……..Y ◯ N ◯ If yes, please list amount: _____ drinks per day/week/month/year

Do you drink caffeinated drinks...Y ◯ N ◯ If yes, please list amount and type: _____ per day/week/month/year

Approximately how many cups of water do you drink per day?_____

How many times are you physically active per week?_____On average, how long are your bouts of activity?_____

Female History:

Are you pregnant?.....Y ◯ N◯ If yes, how many weeks?_____weeks

Number of children_____ Number of pregnancies_____

Any irregularities with your menstrual cycle?....Y◯ N ◯ If yes, please explain:

_____

Thank you for completing this intake questionnaire. By signing below you certify that all the information provided is accurate and complete. Additionally you are consenting to the release of this information to your provider, the clinic, the insurance company or other entity responsible for payment and any other healthcare provider that is necessary for co-management:

Patient Signature:_____ *Date*:_____/_____/_____ *Time*:_____