FREEDMAN CHIROPRACTIC CENTER, LLC
INITIAL INTAKE FORM – ANSWER ALL QUESTIONS

Today's Date: ________________ HRN: ____________________

Whom may we thank for referring you to this office? → ____

PATIENT DEMOGRAPHICS

Name:____________________________ Preferred Pronouns__________ Birth Date:_____/_____/_____ Age______ ☐Male ☐Female

Address: ____________________________________ City: ______________________________ State: _____ Zip: ___________

E-mail Address: ________________________________ Home Phone: _____________________ Mobile Phone:______________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: ___________________________

Social Security #: _______________________________ Driver's License #: ____

Employer: ___________________________________ Occupation: ____

Spouse's Name ____________________________________ Spouse's Employer ______________________________________

Children's names and their ages: ____

Emergency Contact and number: ____ Relationship: ____________________

Cell Carrier (Verizon, AT&T etc.):________________________ Do you authorize this office to send emails? ☐ Yes ☐ No

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office in their order of importance:

#1:____ *Rate this complaint by number:* (NO PAIN) 0-10 (WORST PAIN)

Right Now:________ (0-10) On average: ________ (0-10) At it's best: ________ (0-10) At it's worst: ________ (0-10) (Dr. use only) V.P.N. ______________

#2____ *Rate this complaint by number:* (NO PAIN) 0-10 (WORST PAIN)

Right Now:________ (0-10) On average: ________ (0-10) At it's best: ________ (0-10) At it's worst: ________ (0-10) (Dr. use only) V.P.N. ______________

#3:____ *Rate this complaint by number:* (NO PAIN) 0-10 (WORST PAIN)

Right Now:________ (0-10) On average: ________ (0-10) At it's best: ________ (0-10) At it's worst: ________ (0-10) (Dr. use only) V.P.N. ______________

#4:____ *Rate this complaint by number:* (NO PAIN) 0-10 (WORST PAIN)

Right Now:________ (0-10) On average: ________ (0-10) At it's best: ________ (0-10) At it's worst: ________ (0-10) (Dr. use only) V.P.N. ______________

What relieves your symptoms? ____

What makes them feel worse? ____

When did the problem(s) begin? __________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident or injury? ☐ No ☐ Yes, Describe _______________________________

Above condition(s) ever been treated by anyone in the past? ☐No ☐ Yes, by whom and when:__________________________

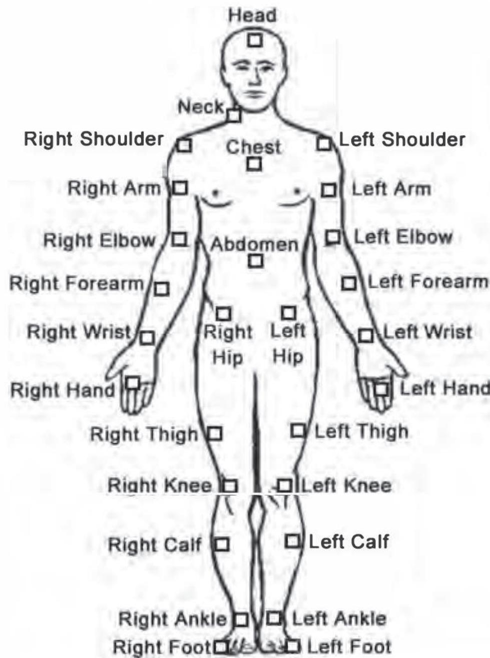
How long were you under care? _____________ What were the results? ____

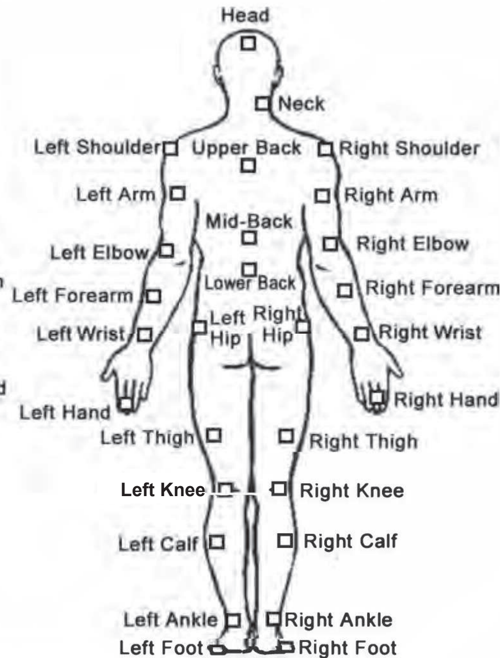
Previous Chiropractor? ☐No ☐ Yes, who? ____

Patient's Name: ____ **Date:** _________________________

PLEASE MARK the areas on the diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling

Elaborate More:





Elaborate More:

_____ **Initial here if your condition doesn't restrict or limit your regular daily activities.**

Or -

LIST RESTRICTED ACTIVITY	AMOUNT YOU CAN PERFORM THIS NOW?	......WITHOUT YOUR CONDITION?
1) ____________________	____________________	____________________
2) ____________________	____________________	____________________
3) ____________________	____________________	____________________
4) ____________________	____________________	____________________

How long does your chief complaint last?

- ❑ Constantly
- ❑ Three to four times a week
- ❑ Frequently
- ❑ Once a week
- ❑ Everyday
- ❑ Two to three times a week
- ❑ Occasionally
- ❑ Every other week
- ❑ Five to six times a week
- ❑ One to two times a week
- ❑ Intermittently
- ❑ Once a month

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem(s):

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Please list all of your past jobs where you experienced physical, chemical or emotional stress:

____

____

List prescription & over the counter drugs you take: ______________________________________

____

____

____

Patient's Name: ____ **Date:** __________________________

If you have been diagnosed with any of the following conditions, for each condition indicate: C - Currently Have P - in the Past N - Never had:

___ Broken Bone	___Dislocations	___ Tumors	___Rheumatoid Arthritis	___ Fracture
___Disability	___Cancer	___ Heart Attack	___Osteoarthritis	___ Diabetes
___ Stroke	___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems
___ Ulcers	___ Neck Pain	___ Loss of Balance	___ Heartburn	___ Frequent Colds/Flu
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problem	___ Impotence/Sexual Dysfun.
___ Low Back Pain	___ Foot or Knee Problem	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A B C)

___ Asthma Other condition(s) not listed: ____

Rate how well you handle emotional stress on a scale from: 0 (Fragile) to 10 (Nothing bothers you): ____________

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect your daily life? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister's ☐ brother's ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of ☐ No ☐ Yes: ______________________________

I hereby authorize Ken Freedman, DC, or the employees of Freedman Chiropractic Center, LLC, to provide services to me or, if applicable, my minor child. I also authorize payment to be made directly to ***Freedman Chiropractic Center, LLC***, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ***Freedman Chiropractic Center, LLC*** for any and all services my minor child / I receive at this office.

______________________________________ ________ / ______ / ______
Patient or Authorized Person's Signature **Date Completed**

______________________________________ ______ / _______ / ______
Doctor's Signature **Date Form Reviewed**