Initial Visit – Intake Form – Page - 1 -

Date ___________ Patient File Number: ___________

Title: Mr. Mrs. Ms Miss (check one)

First Name: ____________________ Middle Initial: ______ Last Name: ___________________________

Address Line 1: ____

Address Line 2: ____

City: _____________________________ State: ___________________ Zip Code: _________________

Home Phone: (______)_________-___________ Work Phone: (________)__________-____________

Cell Phone: (______)_________-______________

Date of Birth: ______/______/________ Sex: Male Female Email: ____________________________

Social Security Number: _________-______-____________ Marital Status: Single Married Other

Employment Status: Employed Full Time Student Part Time Student Other (check one)

Spouse Data

Is your spouse a patient in our office? Yes No

First Name: _____________________ Middle Initial: ______ Last Name: __________________________

Home Phone: (______)_________-_____________ Work Phone: (______)_________-_____________

Employer Data

Name: ____

Address Line 1: _______________________________________

Address Line 2: _______________________________________

Reviewed by doctor__________________________________Date _____________

Revised 5/15/2010

City: ________________________________ State: ____________ Zip Code: _________________

Emergency Contact

Contact Name:____

Contact Phone: (________) _________-_______________

Is it OK to call you at work?
☐ *Yes* ☐ *No*

Name____________________________________ Date ___________ Patient File Number: ___________

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions / Past Health History

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular proced	❑ Cervical disc procedur	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used Occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol Occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionally	❑ Experience stress ofte	❑ Smoke 1 pack or less pe day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (paren	❑ Heart problems (sibling	❑ High blood pressure (parent)	❑ High blood pressure (sibling)

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- ❑ Psychiatric (parent)
- ❑ Psychiatric (sibling)
- ❑ Stroke (parent)
- ❑ Stroke (sibling)
- ❑ Thyroid (parent)
- ❑ Thyroid (sibling)

Recreational Activities:

- ❑ Backpacking
- ❑ Biking
- ❑ Boating
- ❑ Football
- ❑ Golf
- ❑ Racket ball
- ❑ Running
- ❑ Skiing
- ❑ Soccer
- ❑ Swimming
- ❑ Tennis
- ❑ Walking
- ❑ Weightlifting

Male Children:

- ❑ Under 6 years
- ❑ Under 10 years
- ❑ Under 19 years

Female Children:

- ❑ Under 6 years
- ❑ Under 10 years
- ❑ Under 19 years

Occupational Activities:

- ❑ Administration
- ❑ Business owner
- ❑ Clerical/secretarial
- ❑ Computer user
- ❑ Construction
- ❑ Daycare/childcare
- ❑ Executive/legal
- ❑ Food service industry
- ❑ Health care
- ❑ Heavy equipment operator
- ❑ Heavy manual labor
- ❑ Home services
- ❑ Household
- ❑ Light manual labor
- ❑ Manufacturing
- ❑ Medium manual labor
- ❑ Military
- ❑ Police/fire
- ❑ Professional services
- ❑ Retail worker
- ❑ Teacher
- ❑ Truck driver
- ❑
- ❑

Name_________________________________ **Date** ___________ **Patient File Number:** ___________

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:	Present	No Past	☐ No
Poor Circulation	☐	☐	☐
High Blood Pressure	☐	☐	☐
Aortic Aneurism	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Attack	☐	☐	☐
Chest Pain	☐	☐	☐
High Cholesterol	☐	☐	☐
Pace Maker	☐	☐	☐
Jaw Pain	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Swelling of Legs	☐	☐	☐

Genitourinary:	Present	No Past	☐ No
Kidney Disease	☐	☐	☐
Lower Side Pain	☐	☐	☐
Burning Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Blood in urine	☐	☐	☐
Kidney Stone	☐	☐	☐

Hematologic/lymph:	Present	No Past	☐ No

Ears/Nose/Throat:	Present	No Past	☐ No
Dizziness	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinus Infection	☐	☐	☐
Nosebleed	☐	☐	☐
Sore Throat	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Bleeding Gums	☐	☐	☐

Eyes:	Present	No Past	☐ No
Glaucoma	☐	☐	☐
Double Vision	☐	☐	☐
Blurred Vision	☐	☐	☐

Integumentary:	Present	No Past	☐ No
Skin lesions	☐	☐	☐
Skin Disease	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Rashes	☐	☐	☐
Skin Ulcers	☐	☐	☐

Reviewed by doctor___________________________________**Date**

Hepatitis	☐	☐	☐
Blood Clots	☐	☐	☐
Cancer	☐	☐	☐
Easy Bruising	☐	☐	☐
Easy Bleeding	☐	☐	☐
Fevers/Chills/Sweats	☐	☐	☐

Allergic/Immunologic:	***No***	☐	
	Present	***Past***	***No***
Hives	☐	☐	☐
Immune Disorder	☐	☐	☐
HIV/AIDS	☐	☐	☐
Allergy Shots	☐	☐	☐
Cortisone Use	☐	☐	☐

Respiratory:		***No***	☐
	Present	***Past***	***No***
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of Breath	☐	☐	☐
Emphysema	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐

Name**_____________________________________** ***Date*** **____________** ***Patient File Number:*** **____________**

Gastrointestinal:		***No***	☐
	Present	***Past***	***No***
Gallbladder Probs.	☐	☐	☐
Bowel Problems	☐	☐	☐
Constipation	☐	☐	☐
Liver Problems	☐	☐	☐
Ulcers	☐	☐	☐
Diarrhea	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Bloody Stools	☐	☐	☐
Poor Appetite	☐	☐	☐

Neurologic:		***No***	☐
	Presen t	***Past***	***No***
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Head Injury	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Numbness	☐	☐	☐
Severe Headaches	☐	☐	☐
Pinched Nerves	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Carpal Tunnel	☐	☐	☐
Spinning/Balance	☐	☐	☐

Musculoskeletal:		***No***	☐
	Present	***Past***	***No***
Gout	☐	☐	☐
Arthritis	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Weakness	☐	☐	☐
Osteoporosis	☐	☐	☐
Broken Bones	☐	☐	☐
Joints Replaced	☐	☐	☐

Endocrine:		***No***	☐
	Present	***Past***	***No***
Thyroid Disease	☐	☐	☐
Diabetes	☐	☐	☐
Hair Loss	☐	☐	☐
Menopausal	☐	☐	☐
Menstrual Problems	☐	☐	☐

Reviewed by doctor**___________________________________*****Date*** **______________**

Psychiatric:		***No***	☐
	Present	***Past***	***No***
Depression	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Unusual Stress	☐	☐	☐

Constitutional:		***No***	☐
	Present	***Past***	***No***
Weight Loss/Gain	☐	☐	☐
Energy Level Problem	☐	☐	☐
Difficulty Sleeping	☐	☐	☐

Name___________________________________ Date ___________ Patient File Number: ___________

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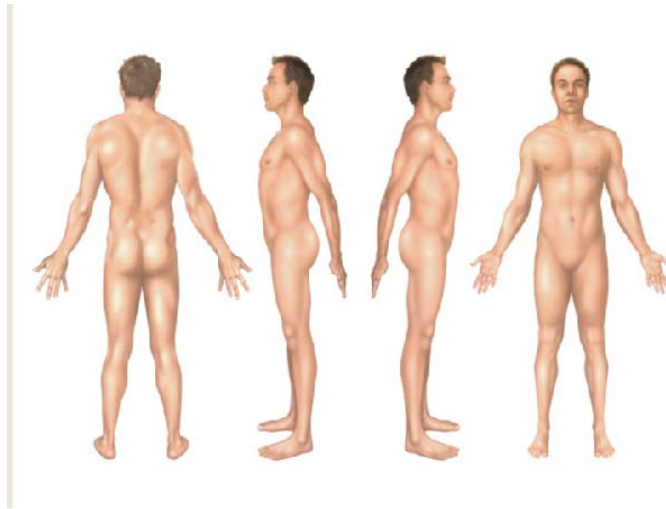
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness   X = Burning   / = Stabbing   0 = Pins & Needles   + = Dull Ache



Describe your symptoms causing you to seek treatment: ____

____

When did your symptoms start? (Onset) Month_____________ Day_____________ Year____________

How did your symptoms begin?____

How often do you experience your symptoms?

- ❑ ***Constantly (76-100% of the day)***
- ❑ ***Frequently (51-75% of the day)***
- ❑ ***Occasionally (26-50% of the day)***
- ❑ ***Intermittently (0-25% of the day)***

What describes the nature of your symptoms?

- ❑ ***Sharp***
- ❑ ***Dull ache***
- ❑ ***Numb***
- ❑ ***Shooting***
- ❑ ***Burning***
- ❑ ***Tingling***
- ❑ ***Stabbing***

How are your symptoms changing?

- ❑ ***Getting better***
- ❑ ***Not changing***
- ❑ ***Getting worse***

During the past 4 weeks, indicate the average <u>intensity</u> of your symptoms: (0 = None to 10 = Unbearable

❑ ***0 None***	❑ ***1***	❑ ***2***	❑ ***3***
❑ ***4***	❑ ***5***	❑ ***6***	❑ ***7***
❑ ***8***	❑ ***9***	❑ ***10 Unbearable***	

Name________________________________ ***Date*** __________ ***Patient File Number:*** __________

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During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

❑ ***Not at all*** ❑ ***A little bit*** ❑ ***Moderately*** ❑ ***Quite a bit***
❑ ***Extremely***

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

❑ ***All of the time*** ❑ ***Most of the time*** ❑ ***Some of the time*** ❑ ***A little of the time***
❑ ***None of the time***

In general, would you say your overall health right now is….

❑ ***Excellent*** ❑ ***Very good*** ❑ ***Good*** ❑ ***Fair***
❑ ***Poor***

Who have you seen for your symptoms:

❑ ***No one*** ❑ ***Other Chiropractor*** ❑ ***Medical Doctor*** ❑ ***Physical Therapist***
❑ ***Other***

What treatment did you receive for your symptoms?

❑ ***Adjustments*** ❑ ***Physical Therapy*** ❑ ***Medication*** ❑ ***Surgery***
❑ ***Other***

When did you receive this treatment?

❑ ***In the last month*** ❑ ***2 – 3 months ago*** ❑ ***3 – 6 months ago*** ❑ ***6 months to 1 year ago***
❑ ***1 – 2 years ago*** ❑ ***2 – 5 years ago*** ❑ ***5 – 10 years ago***

What tests have you had for your symptoms?

❑ ***X-rays*** ❑ ***MRI*** ❑ ***CT Scan*** ❑ ***Other***

When were these tests done?

❑ ***In the last month*** ❑ ***2 – 3 months ago*** ❑ ***3 – 6 months ago*** ❑ ***6 months to 1 year ago***
❑ ***1 - 2 years ago*** ❑ ***2 – 5 years ago*** ❑ ***5 – 10 years ago***

Have you had similar symptoms in the past?

❑ ***Yes*** ❑ ***No***

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ ***This Office*** ❑ ***Other Chiropractor*** ❑ ***Medical Doctor*** ❑ ***Physical Therapist***
❑ ***Other***

What is your occupation?

❑ ***Professional/Executive*** ❑ ***White Collar/Secretarial*** ❑ ***Tradesperson*** ❑ ***Laborer***
❑ ***Homemaker*** ❑ ***Full-time Student*** ❑ ***Retired*** ❑ ***Other***

If you are not retired, a homemaker or a student, what is your work status?

❑ ***Full-time*** ❑ ***Part-time*** ❑ ***Self-employed*** ❑ ***Unemployed***
❑ ***Off work*** ❑ ***Other***

Thank you - Please return to the front desk

Reviewed by doctor_____________________________________Date