Patient Intake Form

For Office Use Only
Date: ____________________
Acct #:____________________

Name: ______________________________ Social Security# ___________________
Address:____ City _____________ State_____ Zip__________
E-Mail address: _______________________ Age______ D.O.B.__________ Race________ Sex: Male/ Female
Marital: M S W D Cell Phone:______________________ Home Phone: _____________________________
Employer __________________________ Occupation _________________ Office Phone__________________
Name of Emergency Contact___________________ Address _________________________ Phone ___________
Family Medical Doctor____
Referred By: ____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ____________________________
Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____________________________________
Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _______________
Briefly describe the accident, injury or illness:____
____
Have you had difficulty sleeping since the accident? ❑Yes ❑No
List any tests, studies or medications received for this condition:
❑Tests/Studies: ____
❑Medications: ____
Where you admitted to the hospital due to this condition: ❑Yes ❑No
If yes, what hospital? ______________________Transported by? ❑Ambulance ❑Police ❑Other: ___________________
Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________
List the hospital procedures received: ____

STRESS LEVELS:

How would you rate your stress level? ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
Explain:____
Where in your body do you hold or carry your stress? ____

List symptoms you are experiencing today: Choose the severity level associated with each symptom
_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
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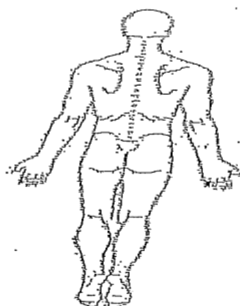
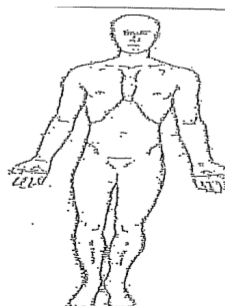
Please mark area(s) of complaint below:

When, or approximately when did the complaint start? ____

Is your condition □Constant □ Intermittent (occurs on and off)?

What makes your pain decrease? ____

What makes your pain increase? ____

Has there been any changes in your bodily functions? □Urination □Defecation □Vision □Respiration □Digestion Other: _____________

Does your condition affect your daily activities? □Yes □No If yes please explain:

____

What type of work do you do? ____

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ___________________ To: ___________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _________________________________

Habits		**EXERCISE**	**FAMILY HISTORY**				
				Diabetes	Cancer	Back Pain	Other
❑ Smoker	Packs per day: ______	□None					
❑Drinking	Alcohol cups/ day	□Moderate	Mother	❑	❑	❑	❑
❑Coffee	Cups/Day: _______	□Daily	Father	❑	❑	❑	❑
❑Soft Drink	Bottles or Cans/Day: _____	Type:_________	Sibling(s)	❑	❑	❑	❑
❑Water	Cups/Day: _______						

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, which ones? ____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____________________________________

Do you have allergies to medication? ❑Yes ❑No

If Yes, please list: ____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		**DATE**		**DATE**	
________________	Back Operation	________________	Hernia	________________	Gall Bladder
________________	Female Organs	________________	Thyroid	________________	Stomach

Other ____

Do you have a Pacemaker? □Yes □No

Any Unexplained weight loss (more than 10 lbs) □Yes □No

Have you ever had X-rays taken? ❑Yes ❑No When? __________________ By Whom? ____________________________

For what ailments were these X-rays taken? ____

Please list any past symptoms you would like for us to be aware of: ____

____

____

Please check the box for any current symptom listed

GENERAL SYMPTOMS

- ❑ Diabetes
- ❑ Epilepsy
- ❑ Anemia
- ❑ HIV
- ❑ Headache

GASTRO-INTESTINAL

- ❑ Constipation
- ❑ Hepatitis
- ❑ Stomach Pain
- ❑ Irritable Bowel

NOSE/THROAT/EYE/EAR

- ❑ Thyroid Problems
- ❑ Hashimoto Thyroiditis

AUTOIMMUNE

- ❑ Multiple Sclerosis
- ❑ Graves Disease
- ❑ Ankylosing Spondylitis
- ❑ Lupus
- ❑ Rheumatoid Arthritis

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Chest Pain
- ❑ Heart Disease

Specify:________________

- ❑ Strokes
- ❑ Irregular Heart Beat

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Polysystic Ovarian Syndrome (PCOS)
- ❑ Pregnant

______________ Last Menstrual Period

- ❑ Oral Contraceptive (Birth Control)

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these services to be performed. It is understood and agreed any x-rays and images are for examination only and the x-rays will remain the property of this office.

Patient's/Guardian's Signature: ____ **Date:** ______________________