New Patient Intake Form

Please fill out all questions thoroughly. Please Circle or mark "X" next to the YES/NO questions. If a question does not apply, please fill in the space with "No" or "None"

Date:_____

PERSONAL INFORMATION

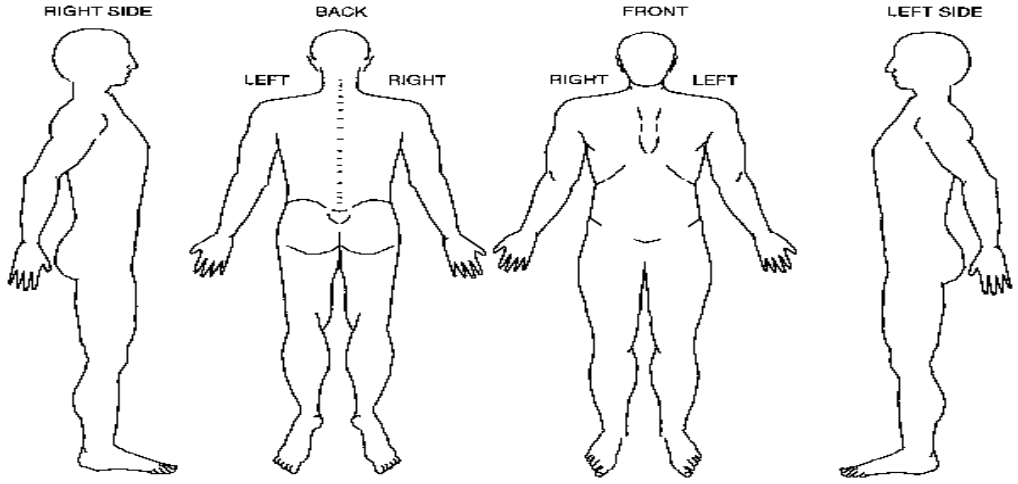
Last Name:_____First Name:_____MI____
DOB: _____Age: _____Ethnicity:_____
Address:_____City:_____
_____State:_____ZIP:_____
Primary Phone #: _____Alternate Phone #:_____
Email Address:_____
Occupation:_____SSN#_____
Marital Status:_____Spouse's Name:_____Phone #:_____
Emergency Contact:_____Relation:_____Phone #:_____
How did you hear about this office?_____
Primary Physician_____Physician Phone #_____
Insurance Provider Name_____ID #_____
Have you ever visited a chiropractor before?_____
Are you taking and BLOODTHINNERS? (Xarelto, Pradaxa, Warfarin, Eliquis, Coumadin, etc.)_____

CHIEF COMPLAINT(S)

List the reason for today's office visit:
1.)_____
2.)_____
3.)_____
Were you hospitalized for any of these conditions? YES☐ NO☐
Have you received any imaging studies for any of the listed complaints? YES☐ NO☐

IN REGARDS TO THE MAIN COMPLAINT (#1 above):

Mark on the diagram where you pain is exactly if possible. Use the letter code listed:
A= Ache B= Burning N=Numbness P= Pins & Needles S=Stabbing X=Other



How long have you had this complaint?_____
When did it start?_____
Is this a new problem?_____
What makes your problem better?_____
What makes your problem worse?_____
On a 0-10 pain scale (0= no pain; 10= worst pain of your life), rate your pain now, and at its worst._____
Is your pain constant or intermittent?_____
How does this problem affect your daily life?_____

_____
Do you notice if your pain is worse at certain times of the day?_____

_____
Have you seen another healthcare provider for this problem?_____
Have you been treated for this problem previously?_____
What treatment did you receive?_____
Did the treatment help?_____

In regards to your chief complaint or any prior complaint, have you ever had…

Night Sweats?	YES ☐	NO ☐
Pain that wakes you up at night?	YES ☐	NO ☐
Unexplained weight loss?	YES ☐	NO ☐
Unexplained weight gain?	YES ☐	NO ☐
Bowel/Bladder problems?	YES ☐	NO ☐
Loss of sensation in the buttocks/inner thighs?	YES ☐	NO ☐
Headaches?	YES ☐	NO ☐
Recent Fever?	YES ☐	NO ☐
Pain with no position of relief?	YES ☐	NO ☐
Painful Urination?	YES ☐	NO ☐
Blood in the urine/stool?	YES ☐	NO ☐

GENERAL HISTORY INFORMATION

Height_____Weight_____Usual Weight_____
Lowest/highest weight in past 5 years:_____/_____
Infections_____
History of Cancer_____
Recent Trauma_____
Hospitalizations? List when and why:_____
_____
_____
Current Medications? List here: _____
_____
_____

Current Vitamins/Supplements? List here:_____
_____
_____

Allergies of Food Sensitivities? List here:_____
_____
_____
_____

Previous Surgeries or Operations? List type and date here:_____
_____
_____
History of sexually transmitted diseases?_____
Personal History of:
Cancer: YES☐ NO☐ If yes, list what type and when:_____
Diabetes: YES☐ NO☐ If yes, when was it diagnosed?_____
Heart Disease: YES☐ NO☐ If yes, when was it diagnosed?_____
Stroke: YES☐ NO☐ If yes, when?_____
History of eating disorders? List when and what:_____
_____

FAMILY MEDICAL HISTORY
To the best of your knowledge, has your mother, father, siblings, or grandparents ever had any of the following conditions? If so, list who and the age of onset.

High cholesterol _____Anxiety/Panic Attacks_____
Arthritis _____Ulcerative Colitis_____
Alcoholism _____Obesity_____
Thyroid Disease _____Asthma_____
Heart Disease _____Crohn's Disease_____
Kidney Disease _____Hypertension_____
Osteoporosis _____Eczema_____

Stroke _____ Autoimmune Disease _____
Cancer _____ Mental Illness _____
Allergies _____ Depression _____
Alzheimer's _____ Diabetes _____
Other: _____

SOCIAL HISTORY

Stress Level (highlight): None ☐ Minimal ☐ Moderate ☐ High ☐
Physical activity at work: None ☐ Minimal ☐ Moderate ☐ High ☐
Stressors? List what and rate on scale of 1-10: _____
_____
_____
How many days per week do you exercise? _____
What type of exercise do you do? _____
Alcohol use? How often? How much? _____
Tobacco use? How often? How much? _____
Recreational drug use? _____
Sexual Activity? How many partners? _____

Please recall all of the food and drink you have eaten in the previous 24 hours.
Record amounts if possible:
Breakfast _____
Lunch _____
Dinner _____
Snacks/Other _____
Beverages: _____
Do you skip meals? YES ☐ NO ☐
If YES, explain further: _____
Do you have times where you eat uncontrollably? YES ☐ NO ☐
If YES, explain further: _____

Please mark if these apply:

Do you eat because you are:
_____Lonely _____Bored _____ Anxious _____ Stressed _____Sad
_____Depressed _____ Happy _____ Angry _____Tired
Where do you eat?
_____ In the car _____ In bed _____ Watching TV _____On the Computer
_____Reading _____ Standing Up _____Sitting Down _____When not Hungry

REVIEW OF SYSTEMS

Please circle or highlight any of the symptoms you have had previously of presently, regardless of the chief complaint.

Constitutional:
A. Recent weight change? _____

B. Weakness, fatigue or chills?_____
C. Convulsions?_____
D. Fainting or Dizziness?_____
E. Tremors?_____
F. Difficulty Sleeping?_____
G. Nausea?_____

Eyes:
A. Difficulty seeing? _____
B. Contact Lenses? _____
C. Temporary loss of vision?_____
D. Loss of or excessive tearing?_____

Ears, Nose, Throat:
A. Dentures _____
B. Problems with hearing? _____
C. Hoarseness?_____
D. Pain or lump in the front of the neck?_____
E. Vision problems?_____
F. Discharge?_____

Cardiovascular:
A. Chest pain (heart pain, angina)? _____
B. Known heart rhythm problems? _____
C. Leaky heart valves? _____
D. Problems with circulation? _____
E. High or low blood pressure?_____

Respiratory:
A. Chronic cough? _____
B. Shortness of breath with exertion? _____
C. Wheezing or asthma symptoms?_____
D. Coughing up blood or mucus?_____
E. Wheezing or chest pain?_____

Gastrointestinal:
A. Constipation/ diarrhea? _____
B. History of jaundice? _____
C. Recent change in appetite? _____
D. Blood per rectum? _____
E. Frequent heartburn or indigestion?_____
F. Hemorrhoids?_____
G: Gall bladder issues?_____

H. Vomiting /vomiting up blood?_____
I. Bloating?_____
J. Loss of appetite/excessive appetite?_____

Genitourinary:
A. Frequent bladder infections? _____
B. Frequent nighttime urination? _____
C. Incontinence?_____
D. Blood/pus in the urine?_____
E. Kidney infection?_____

Musculoskeletal:
A. Joint pain requiring medicine? _____
B. Calf or leg pain with walking? _____
C. Arthritis?_____
D. Pain/numbness? Where?_____
E. Joint Swelling?_____
F. Hernia?_____

Skin:
A. Rashes? _____
B. Skin Cancers? _____
C. Ulcers?_____
D. Other major skin problems?_____
E. Bruise easily?_____
F. Varicose veins?_____

Neurological:
A. TIA's or minor stroke? _____
B. Recent numbness or weakness? _____
C. History of seizures?_____
D. History of concussions?_____

Psychological:
A. Depression? _____
B. Anxiety? _____
C. Other psychiatric problems?_____
D. Low energy levels?_____
E. Mood Swings?_____
F. ADHD/ADD?_____

Endocrine:
A. History of high or low blood sugar? _____
B. Thyroid problems?_____

Blood/Lymph:
A. Bleeding tendencies/bruising, or frequent nose bleeds? _____
B. Any history of anemia? _____
C. Do you have sickle cell disease?_____

Breasts:
A. Pain? _____
B. Discharge?_____
C. Other changes or abnormalities?_____

DATE OF LAST (and reason for test)…
A. Physical examination:_____
B. Blood test:_____
C. X-ray:_____
D: MRI:_____
E: Other imaging study:_____
F: Urine test:_____

FEMALES ONLY – Gynecological History:
A. Age of onset of menses: _____
B. Age of menopause: _____
C. Age at first pregnancy: _____
D. Number of children: _____
E. Last menstrual period: _____
F. Are you pregnant now? Yes☐ No☐
G. Is there a possibility you of becoming pregnant? Yes☐ No☐
H. Do you take birth control or have ever taken birth control? If yes, when and for how long?_____
I. Hot flashes?_____
J. Vaginal discharge?_____