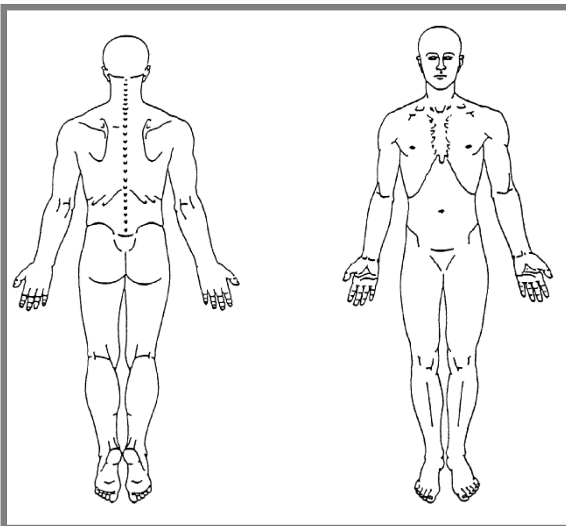
LIGHTHOUSE
CHIROPRACTIC

Patient Intake Form

Patient name:______________________ Age: _______ Birth Date:_____/_____/_____
Address:______________________ City:______________ State:_______ Zip Code:______________
Home phone:______________ Work phone:______________ Cell phone:______________
Email address:______________________
Occupation:______________________
How did you hear about us?______________________
Would you like this office to verify your health insurance coverage? ______________________

EMERGENCY CONTACT INFORMATION
Emergency Contact Person:______________________
Phone#:______________________Relationship:______________________

Do you have a primary complaint?______________________
When did this complaint begin?______________________How did it begin?______________
What makes it better?______________________
What makes it worse?______________________



If you are currently experiencing pain, is it:
(mark all that apply)
__Sharp __Dull ache __Burning __Throbbing
__Stabbing __Shooting __Numbness __Tingling
Does the pain:
__Come & go __Constant

How would you rate your pain?
0=no pain, 10=worst possible pain

0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***

Please mark on the diagram where the pain(s) is/are occurring.

How often does this pain occur? *__Hourly __Daily __Weekly __Occasionally __N/A*

If the pain travels, where does it go? ______________________

Since the onset, has the complaint? *__Improved __Worsened __About the same __N/A __not sure*

Is this keeping you from …
__Working __Exercising __Sports/hobbies __Driving __Sleeping __Quality Family Time

How would you rate your HEALTH RIGHT NOW?
0=Unhealthy, 10=Optimum Health

0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***

Would you like to be: *__HEALTHY __Pain FREE __NOT sick*

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Below is a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Mark the following conditions that are **currently** a cause of significant concern.

*Please mark **S** for self or **F** for family member.*

Current Significant **Musculo – Skeletal** concerns			
2 Back/Neck Pain	2 Carpel Tunnel	2 Scoliosis	2 Joint pain
2 Leg Pain/Sciatica	2 Headaches	2 Arthritis	2 Swollen joint

Current Significant **Cardiovascular** concerns			
2 Chest Pain/Angina	2 Blood pressure Problems	2 Anemia	
2 Cold Extremities		2 Varicose Veins	
2 Heart Problems	2 Arterio/Athero sclerosis	2 Stroke	

Current Significant **Gastrointestinal** concerns			
2 Abnormal Appetite	2 Nausea	2 Constipation	2 Bad Breath
2 Increased Thirst	2 Vomiting	2 Bloating/Gas	2 Heartburn
2 Ulcers	2 Diarrhea	2 GERD/Acid Reflux	2 Gall Stones

Current Significant **Urinary/Reproductive** concerns			
2 Kidney Infection	2 Bladder Trouble	2 Fibroids	2 Hot Flashes
2 Kidney Stones	2 Impotence	2 Cysts	2 Cramps
2 Frequent Urination	2 Prostrate Problems	2 Excessive Menstruation	2 PMS
2 Painful Urination	2 Decreased Sex Drive	2 Painful Menstruation	2 STD's
2 Discolored Urination	2 Hemorrhoids	2 Endometriosis	2 Pregnant

Current Significant**Nervous System** concerns			
2 Nervousness	2 Shooting Pain/	2 Seizures	2 Dizziness/Vertigo
2 Anxiety	2 Paralysis	2 Loss of Balance	2 Loss of Taste
2 Numbness/Tingling	2 Forgetfulness	2 Loss of Smell	

Current Significant **General** concerns			
2 Allergies	2 ADD/ADHD	2 Diabetes	2 Herpes Zoster/Simplex
2 Fatigue	2 Colic	2 Autism	2 Hearing
2 Insomnia	2 Lung Problems	2 Heart Disease	2 Dental
2 Depression	2 Cancer	2 Chicken Pox	2 Vision

List medications you are currently taking (including over-the-counter, supplement and herbs).

____
____
____
____
____
____

List any accidents or traumas, when they happened, and what was injured.

____
____
____
____
____
____

Please list any major surgeries:______________________________________Date:__________
______________________________________Date:__________
Name of Primary Care Physician and Approx. Date of last visit:______________________________
Have you been treated for any conditions in the past year? __Yes __No
If yes, please explain:______________________________________
Please include any additional information, concerns or questions would like to add.
____
____

The statements made as to the questions asked on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form an in the file will remain confidential to myself, the doctor, and any other authorized personnel.

Signature:______________________________________ Date:______________