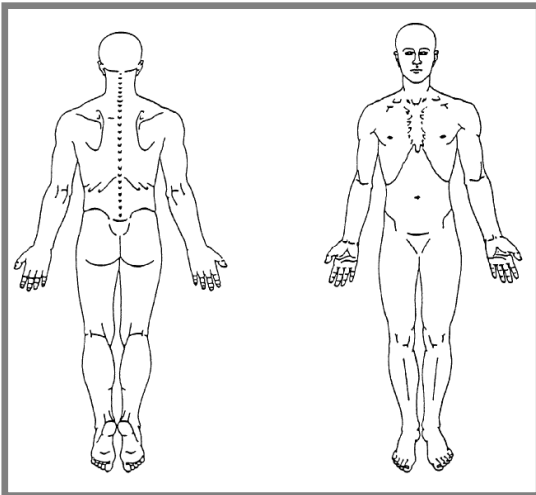


**Patient name:** \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 Marital Status: S M W D How many children: \_\_\_\_\_ Ages: \_\_\_\_\_  
 Would you like this office to verify your health insurance coverage? \_\_\_\_\_  
 Insurance Coverage: \_\_\_ Medicare \_\_\_ Auto Accident \_\_\_ Worker's Comp \_\_\_ Major Medical \_\_\_ Other

### 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? \_\_\_\_\_



**Please mark on the diagram where your pain is occurring.**

**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**

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

0=Unhealthy, 10=Optimum Health

Would you like to be: \_\_\_ *HEALTHY* \_\_\_ *Pain FREE* \_\_\_ *NOT sick*

**\*Women Only:** Are you pregnant or is there any possibility you may be pregnant? Yes \_\_\_ No \_\_\_ Uncertain \_\_\_

# Patient Intake Form

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**

- |                     |                 |             |                 |
|---------------------|-----------------|-------------|-----------------|
| ▪ Back/Neck Pain    | ▪ Carpel Tunnel | ▪ Scoliosis | ▪ Joint pain    |
| ▪ Leg Pain/Sciatica | ▪ Headaches     | ▪ Arthritis | ▪ Swollen joint |

**Current Significant Cardiovascular concerns**

- |                     |                            |                  |
|---------------------|----------------------------|------------------|
| ▪ Chest Pain/Angina | ▪ Blood pressure Problems  | ▪ Anemia         |
| ▪ Cold Extremities  | ▪ Arterio/Athero sclerosis | ▪ Varicose Veins |
| ▪ Heart Problems    |                            | ▪ Stroke         |

**Current Significant Gastrointestinal concerns**

- |                     |            |                    |               |
|---------------------|------------|--------------------|---------------|
| ▪ Abnormal Appetite | ▪ Nausea   | ▪ Constipation     | ▪ Bad Breath  |
| ▪ Increased Thirst  | ▪ Vomiting | ▪ Bloating/Gas     | ▪ Heartburn   |
| ▪ Ulcers            | ▪ Diarrhea | ▪ GERD/Acid Reflux | ▪ Gall Stones |

**Current Significant Urinary/Reproductive concerns**

- |                        |                       |                          |               |
|------------------------|-----------------------|--------------------------|---------------|
| ▪ Kidney Infection     | ▪ Bladder Trouble     | ▪ Fibroids               | ▪ Hot Flashes |
| ▪ Kidney Stones        | ▪ Impotence           | ▪ Cysts                  | ▪ Cramps      |
| ▪ Frequent Urination   | ▪ Prostate Problems   | ▪ Excessive Menstruation | ▪ PMS         |
| ▪ Painful Urination    | ▪ Decreased Sex Drive | ▪ Painful Menstruation   | ▪ STD's       |
| ▪ Discolored Urination | ▪ Hemorrhoids         | ▪ Endometriosis          | ▪ Pregnant    |

**Current Significant Nervous System concerns**

- |                     |                  |                   |                     |
|---------------------|------------------|-------------------|---------------------|
| ▪ Nervousness       | ▪ Shooting Pain/ | ▪ Seizures        | ▪ Dizziness/Vertigo |
| ▪ Anxiety           | ▪ Paralysis      | ▪ Loss of Balance | ▪ Loss of Taste     |
| ▪ Numbness/Tingling | ▪ Forgetfulness  | ▪ Loss of Smell   |                     |

**Current Significant General concerns**

- |              |                 |                 |                         |
|--------------|-----------------|-----------------|-------------------------|
| ▪ Allergies  | ▪ ADD/ADHD      | ▪ Diabetes      | ▪ Herpes Zoster/Simplex |
| ▪ Fatigue    | ▪ Colic         | ▪ Autism        | ▪ Hearing               |
| ▪ Insomnia   | ▪ Lung Problems | ▪ Heart Disease | ▪ Dental                |
| ▪ Depression | ▪ Cancer        | ▪ Chicken Pox   | ▪ 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 and in the file will remain confidential to myself, the doctor, and any other authorized personnel.

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_