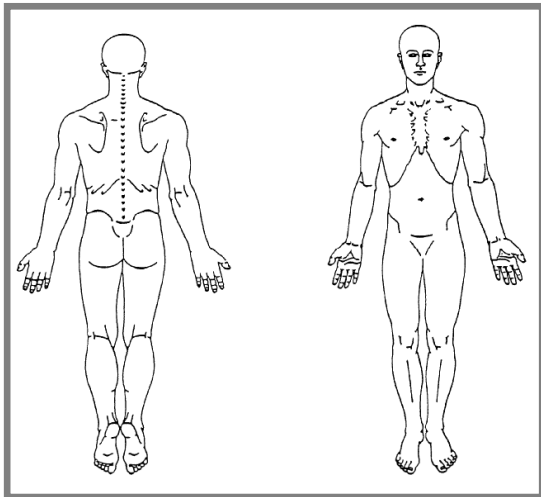


Patient name: _____ Age: _____ Birth Date: ____/____/____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home phone: _____ Work phone: _____ Cell phone: _____
 Email address: _____
 Occupation: _____ Employer: _____
 How did you hear about us? _____
 Marital Status: S M W D How many children: _____ 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: _____