Patient Intake Form

(Please print clearly)

Today's Date:		**Location:**		
Name:		**Race:**	**Sex: M F**	**R L B Handed**
Street:		**City/State/Zip**		
Phone H:	**W:**	**C:**	**Email:**	
DOB: mm/dd/yyyy	**Age:**	**Blood type:**	**Ht:**	**Wt:**
Married / Divorced / Single / Widowed / Separated				
Emergency Contact's Name and #:				
Occupation				
Occupational Stresses: (Chemical, physical, psychological, etc.)				
Hobbies/Past-times:		**Denomination/Spiritual Path:**		
Referred by:		**Physician:**	**Phone:**	

Main Concern/health issue:_____

_____

How does it affect your daily living?_____

_____

Please answer all questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they all are very important to help diagnosis and formulate a treatment plan specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more detail.

Recent Exams: (give dates) **Physical:**_____**Eye:**_____
Dental:_____ **Ob/Gyn:**_____ **Specialist:**_____

What is your philosophy of healthcare?_____

Do you have health questions that do not get answered at the doctor's office? Y N_____

_____

_____

Your **Physical** health status now feels: **(poor) 1----------10 (ideal)**

Your **Mental** health status now feels: **(poor) 1----------10 (ideal)**

Your **Daily Work** stress levels now feel: **(poor) 1----------10 (ideal)**

Your **Daily or Social** stress levels feel: **(poor) 1----------10 (ideal)**

Your **Home Life** stress levels now feel: **(poor) 1----------10 (ideal)**

Your ability to handle recent stresses: **(poor) 1----------10 (ideal)**

What special topic/s would you like to ask about at your consultation? _____

_____

_____

Patient Intake Form Name:_____ **Date:**_____

Healthcare: Other Independent or Concurrent Therapies: Past (P) and/or Current (C)

1. ____ Chiropractic
2. ____ Chiro for family, pets
3. ____ Acupuncture
4. ____ Therapeutic Massage
5. ____ Naturopathic
6. ____ Oriental Medicine
7. ____ Nutritional Consult
8. ____ Medical Treatment
9. ____ Specialist
10. ____ Natural Healer
11. ____ Spiritual Healer
12. ____ Energy Work

Diagnostic or Routine Exams: Please list area, Dr. and reason ordered, date and location of exam if known.

13. ____ X-rays
14. ____ MRI
15. ____ CAT Scan
16. ____ Blood draw
17. ____ Ultrasound
18. ____ Upper/lower GI
19. ____ DEXA Scan
20. ____ Breast Exam
21. ____ Prostate Exam
22. ____ Eye Exam
23. ____ Dental Exam
24. ____ Colonoscopy
25. ____ Other_____
26. ____ Other_____
27. ____ Other_____

Medical History: Current = C Past = P (greater than 6 months) include dates if possible for both

Significant Illnesses

28. ____ Allergies
29. ____ Arthritis
30. ____ Asthma
31. ____ Cancer
32. ____ Depression
33. ____ Diabetes
34. ____ Hepatitis A / B / C
35. ____ Heart disease
36. ____ High blood pressure
37. ____ Low blood pressure
38. ____ Lung disease
39. ____ Neurological
40. ____ Psychological
41. ____ Rheumatic Fever
42. ____ Seizures
43. ____ Thyroid disease
44. ____ Vascular disease
45. ____ Other

Illness/Injuries/Surgeries/Hospitalizations:

46. ____ Broken bones
47. ____ Burns
48. ____ Car accidents
49. ____ Concussion
50. ____ Fallen down/upstairs
51. ____ Fallen from any height
52. ____ Fallen on ice
53. ____ Feeling un-coordinated
54. ____ Fevers
55. ____ Flu/colds
56. ____ Frequent accidents
    Sports injuries
57. ____ Frequent Illness
58. ____ Frequent Infections
59. ____ Head trauma
60. ____ Hospitalizations
61. ____ Infected wounds
62. ____ Loss of consciousness
63. ____ Psychological
    Hospitalization
64. ____ Recreational Injuries
65. ____ Serious cuts
66. ____ Serious Depression
67. ____ Significant trauma
68. ____ Surgeries
69. ____ Transfusions
70. ____ Transplants
71. ____ Tripping/Stumbling
72. ____ Wounds slow to heal

Patient Intake Form Name:_____ **Date:**_____

Childhood

73. ____ Illnesses
74. ____ Traumatic events
75. ____ Immunizations
76. ____ Injuries
77. ____ Other
78. ____ Other

Prescribed/Over the Counter medications and Supplements (Include doses, purpose and duration):

Past Medications and Supplements (3-6 months)

Skin and Hair:

79. ____ Rashes
80. ____ Eczema
81. ____ Hair/skin texture change
82. ____ Ulcerations
83. ____ Pimples
84. ____ Purpura
85. ____ Hives
86. ____ Dandruff
87. ____ Itching
88. ____ Loss of hair
89. ____ New moles/growth
90. ____ Other

General: List times of day or any correlating factors

91. ____ Poor appetite
92. ____ Heavy appetite
93. ____ Change in appetite
94. ____ Weight gain
95. ____ Weight loss
96. ____ Cravings salt/sweet/fats
97. ____ Poor sleep
98. ____ Can't fall asleep easily
99. ____ Wake feeling rested
100. ____ Decreased sleep
101. ____ Heavy sleep
102. ____ Insomnia
103. ____ Apnea/Narcolepsy
104. ____ Sudden awakening at night, time_____
105. ____ Hours of sleep/night
106. ____ Day napping ____ amt
107. ____ Night sweats
108. ____ Cold hands/feet
109. ____ Sudden energy drop
110. ____ Strong thirst hot/cold
111. ____ Fatigue
112. ____ Chills
113. ____ Sudden temp changes
114. ____ Localized weakness
115. ____ Tremors
116. ____ Poor circulation
117. ____ Peculiar tastes/smells
118. ____ Night pain
119. ____ Radiating pain
120. ____ Numbness/tingling
121. ____ Pins and needles
122. ____ Sweats easily
123. ____ Excessive sweating
124. ____ Body odor change
125. ____ Stress
126. ____ Bowel/bladder changes
127. ____ Bleed/bruise easily (where?)

Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc…

128. ____ Neck Pain
129. ____ Muscle Pain
130. ____ Back Pain
131. ____ Joint Pain
132. ____ Other muscle or joint problems?
133. ____ Irretractable night pain
134. ____ Scar tissue adhesions

Patient Intake Form Name:_____ **Date:**_____

Head, Eyes, Ears Nose and Throat: List any noticeable correlation and frequency these conditions occur

135.____ Dizziness
136.____ Migraines
Auras, Sounds, Smells
137.____ Headaches
138.____ Vision problems
139.____ Near/Far sighted
140.____ Blurry vision
141.____ Night Blindness
142.____ Eye strain/pain
143.____ Color blindness
144.____ Cataracts
145.____ Glaucoma
146.____ Spots in eyes
147.____ Ringing in ears
148.____ Poor hearing
149.____ Earaches
150.____ Ear Pain
151.____ Ear discharge
152.____ Heavy ear wax
153.____ Nose bleeds
154.____ Sinus problems
155.____ Mucus
156.____ Dry throat/mouth
157.____ Copious saliva (lots)
158.____ Mouth/tongue sores
159.____ Sore throats
160.____ Other

Dental:

161.____ Teeth problems
162.____ Cavities
163.____ Braces
164.____ Bridges
165.____ Fillings/amalgams
166.____ Crowns gold/porcelain
167.____ Tooth pain
168.____ Head pain
169.____ Jaw pain
170.____ Molars
171.____ Extractions
172.____ Surgeries
173.____ Jaw clicks
174.____ Grinding teeth
175.____ Facial pain
176.____ Implants
177.____ Dentures
178.____ Swollen/bleeding gums
179.____ Periodontal Tx
180.____ Sealants
181.____ Fluoride Tx
182.____ Dry mouth
183.____ Other_____
184.____ Other_____

Neurologic:

185.____ Balance problems
186.____ Vertigo
187.____ Nausea
188.____ Vomiting
189.____ Sudden blurry vision
190.____ Loss of consciousness
191.____ Loss of strength
192.____ Weakness limb/body
193.____ Feel un-coordinated
194.____ Stumbling/tripping
195.____ "Running into walls or things"
196.____ Frequently dropping things
197.____ Loss of hand grip
198. ____ Loss of fine motor skills
199.____ Other_____
200.____ Other_____

Cardio Vascular:

201.____ High blood pressure
202.____ Dizziness
203.____ Blood Clots
204.____ Low blood pressure
205.____ Fainting
206.____ Phlebitis
207.____ Chest Pain
208.____ Cold hands/feet
209.____ Difficulty breathing
210.____ Irregular heartbeat
211.____ Hand/feet swelling
212.____ Rapid pulse
213.____ Heaviness in chest
214.____ Other _____
215.____ Other_____

Patient Intake Form Name:_____**Date:**_____

Respiratory and Lungs:

216._____Persistent Cough
217._____ Coughing Blood
218._____ Difficulty breathing while lying down
219._____ Asthma
220._____ Production of phlegm Y /N _____Color
221._____ Tight chest
222._____ COPD
223._____ Bronchitis
224._____ Pneumonia
225._____ Asthma
226._____ Other

_____

_____

Genito-Urinary:

227._____ Pain w/urination
228._____Loss of bladder function
229._____Wake to urinate _____ x's/ night; time_____
230._____ Kidney stones
231._____ Frequent Urination _____ color _____odor
232._____ Kidney Stones
233._____ Blood in urine
234._____ Venereal disease/STD
235._____ Urgency to urinate
236._____ Impotency
237._____ Prostate problems
238._____ Other _____

_____

_____

_____

Gastrointestinal:

239._____ Nausea
240._____ Gas/bloating
241._____ Bad breath
242._____ Constipation
243._____ Diarrhea
244._____ Pain or cramps
245._____ Vomiting
246._____ Belching
247._____ Rectal pain
248._____ Bloody stools bright/dark red
249._____ Hemorrhoids
250._____ Sensitive abdomen
251._____ Laxative use: ___wk; type_____
252._____ Bowel Changes
253. Bowel movements
_____Frequency/day/wk
_____Color
_____Odor (foul)
_____Form (loose, compact)
Texture (smooth, segmented)
Other_____

_____

_____

_____

Gynecology and pregnancy:

254._____ Age of 1st menses
255._____ Flow (describe)
256._____ Period ___ days
257._____ Clots
258._____ Vaginal Sores
259._____ Vaginal discharge
_____odor
_____color
_____appearance
260._____ Irregular Periods
261._____ Last Menses
262._____ Birth Control type and duration _____
263._____ Number of pregnancies
264._____ Number of births
265._____ Live births
266._____ Premature births; duration of pregnancy?_____
267._____ Miscarriages; What month? _____
268._____ Breast Lumps (tender?)
269._____ PMS
270._____ Mood Changes
271._____ Body Changes
272._____ Cramps
273._____ Bloating
274._____ Nausea
275._____ Vomiting
276._____ Menopause _____
277._____ Last PAP_____
278._____ Last Breast Exam
279._____ Last Ob/GYN Appt

_____

_____

_____

_____

_____

_____

Patient Intake Form Name:_____ **Date:**_____

Appliances or Aids:

280.____ Glasses/Prisms
281.____ Contacts
282.____ Orthotics
283.____ Joint replacement
284.____ Prosthetics
285.____ Implants of any kind
286.____ Braces
287.____ Splints
288.____ Pace Maker
289.____ Hearing Aids
290.____ Other
291.____ Other

_____

_____

Neuropsychological:

292.____ Seizures
293.____ Depression
294.____ Anxiety
295.____ Poor memory
296.____ Foggy thinking
297.____ Bad Temper
298.____ Concussions
299.____ Easily stressed
300.____ Considered/attempted suicide
301.____ Treated for emotional concerns
302.____ Antidepressant medications
303.____ Other neurological or psychological concerns

_____

_____

Lifestyle and Social History:

Stress Screening:

304.____ Can you relax when you want?
305.____ Fall asleep easily?
306.____ Stay asleep all night?
307.____ Have trouble dealing with stress?
308.____ Are you in therapy or counseling? Does it help?
309.____ Is your family safe to express true emotions?
310.____ Are romantic relationships fulfilling?
311.____ Does stress leads to digestive problems?
312.____ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
313.____ Do you vent unpleasant emotions in a satisfying way?
314.____ Do you avoid conflicts at your expense?
315.____ Do you feel your health is out of your hands?
316.____ Have you tried to deal with stress, but couldn't succeed?
317.____ Do you feel capable of resolving your problems, but simply need to know how?
318.____ How much do you love yourself? 0----------100%

_____

_____

_____

_____

Do you find any dysfunction or concern in the following areas?

319.____ Relationship with Family
320.____ Relationships with friends
321.____ Social Skills
322.____ Career
323.____ Work
324.____ Leisure Time
325.____ Hobbies
326.____ Past time activities
327.____ Intimate relationships
328.____ Sex
329.____ Religious Life_____
330.____ Spiritual Path_____
331.____ Childhood Religious teachings
332.____ Past relationships
333.____ Childhood
334.____ School

_____

_____

_____

Patient Intake Form Name:_____ **Date:**_____

Habits: List type and quantities where valid

335.____ Exercise x's/week_____
336.____ Proper diet (Please list typical daily meals)
337.____ Participate in community events
338.____ Sports_____
339.____ Walks_____
340.____ Regular Religious activity
341.____ Regular Spiritual activity
342.____ Seatbelts
343.____ Helmets/Protective gear
344.____ Caffeine/pills/coffee/tea/drinks
345.____ Consume Alcohol
346.____ Crave sugar/salt/fats
347.____ Smoke/chew tobacco
348.____ Recreational drugs use
349.____ Un-protected sex
350.____ Un-necessary risk taking
351.____ Road Rage
352.____ Seek conflict

Nutritional: List typical ounces/servings per week and type

353.____ Drink soda oz/wk_____
354.____ Fruit juices oz/wk_____
355.____ Gatorade oz/wk_____
356.____ Coffee/black tea _____
357.____ Caffeine _____
358.____ Chocolate_____
359.____ Alcohol _____
360.____ health drinks, i.e. Red Bull_____
361.____ Nutritional Shakes_____
362.____ Health bars_____
363.____ Protein powders_____
364.____ Cravings salt/sweet/fats_____
365.____ Meat_____
366.____ Protein _____
367.____ Milk, oz/wk_____
368.____ Dairy, kind _____
_____
369.____ Veg, serving/day_____
370.____ Fruits, serving/day_____
371.____ Vitamins_____
_____
372.____ Supplements_____
_____
373.____ Food Allergies_____
374.____ Other _____
375.____ Other _____

Family History: Medical, psychological, social

376.____ History of Chief Complaint
377.____ Anemia
378.____ Alcoholism
379.____ Allergies
380.____ ALS (Lou Gerhig's)
381.____ Arthritis
382.____ Asthma
383.____ Back/spine problems
384.____ Cancer
385.____ Dementia/Alzheimer's
386.____ Depression
387.____ Diabetes
388.____ Family violence
389.____ Headaches
390.____ Heart Disease
391.____ High blood pressure
392.____ High cholesterol
393.____ Low cholesterol
394.____ Lung disease
395.____ Mental abuse
396.____ Mental illness
397.____ Migraines
398.____ Multiple Sclerosis
399.____ Muscular Dystrophy
400.____ Neglect
401.____ Neuropathy (numbness, tingling, pain, burning)
402.____ Neuromuscular disease
403.____ Parkinson's
404.____ Physical abuse
405.____ Sexual abuse
406.____ Seizures
407.____ Rigid upbringing
408.____ Rigid Religious beliefs
409.____ Stroke
410.____ Suicide (or attempted)
411.____ Thyroid disease
412.____ Tremors
413.____ Vascular disease
414.____ Other_____
415.____ Other_____

Signature_____ Date:_____

INFORMED CONSENT

Some risk is assumed in all treatment modalities, including chiropractic adjustments. Manipulation or adjustment of the human frame carries small risk of injury to weakened or hidden pathology of the vertebral artery in the neck causing death or stroke in reported 1 per 400,000 cases to 1 per 10 million cases. Every effort is made to screen for this and use methods with the lowest risk. Your doctor of chiropractic is the highest licensed professional for specific and safe adjustment of the human frame.

Other complications may rarely include; strain, sprain, dislocation, fracture, disk aggravation, physiotherapy burns, muscle soreness, aches, or other injury. Please ask your doctor of chiropractic if you have any questions.

Subluxation is a misalignment and/or "stuck" joint or tissue, which is found to cause nerve impingement. This interferes with any organ, tissue, or blood vessel supplied by that nerve. Your doctor of chiropractic is trained to look for and find these subluxations, and to correct them with an **adjustment**. Please do not "pop" or "crack" your joints using a thrust of any kind, nor have an unlicensed person do it for you. Not only can you be hurt, you most likely will not achieve the correction you are looking for. Proper stretching can be very beneficial, and painless popping sounds may be heard and are normal, as long as no forceful thrust or impulse is applied.

After a specific adjustment some people experience the effects of renewed nerve flow and circulation to impinged areas that were restricted by their subluxation. These historically have been changes in; sweating patterns, increased respiratory capacity, faster bowel transit time, increased bowel movement frequency, shift in center of balance perception, sleep pattern changes, shoe fit and clothing measurements, differences in walking (gait), and various organ function changes. These subside quickly as the tissue adjusts itself to the restored nerve flow, but may be temporarily necessary in order for the tissue cells to excrete stored wastes.

_____
signature

Date_____

I understand the informed consent and hereby consent to treatment of my minor child named_____

Child's date of birth_____

Parent or Guardian signature:

_____

Date_____

Chief Complaint Worksheet

Patient Name:	**Date:**

Symptom/Complaint:

Onset (**What** caused it & **When** did it begin?):

Provoke (What **worsens** the complaint: position, activity, stress, food/drinks, motion, etc.?):

Palliative (What makes it **better**: ice, OTC, massage, position?):

Quality (Describe what you feel. Is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, pinpoint/general):

Radiation (Does the pain travel from one area to another?):

Reference: What is the worse pain you've ever experienced?

Severity:	At Its Worse: 0 1 2 3 4 5 6 7 8 9 10	Percent of time:	At Its Best: 0 1 2 3 4 5 6 7 8 9 10	Percent of time:

Timing: (Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Possible Social Factor Correlation:

Possible Hospitalization Correlation:

Possible Infection Correlation:

Possible Traumatic Correlation:

Possible Surgical Correlation:

Possible Medication Correlation:

Possible Genetics Correlation:

Patient Name_____ Date_____

Please mark where you have pain or symptoms. Write down how it feels, such as deep or surface, stabbing or dull, throbbing or constant: