connect
CHIROPRACTIC
& WELLNESS

New Patient Intake

Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Date of Birth:_____ Age:_____ Sex(M/F):_____ SS#:_____

Family Status: ☐Single ☐Married ☐Widow ☐Div ☐Sep ☐Partner No. Children_____

Occupation:_____ Employer:_____

How did you hear about us?_____

Emergency Contact:_____ Phone:_____ Relation:_____

Primary Care Physician:_____ Phone:_____

Responsible Party information (if patient is a minor)

Name:_____ Relation to patient:_____Phone: _____

Address (if different):_____ City:_____ State:_____ Zip:_____

Insurance Information

Name of Patient: _____Name of Insured:_____

Insurance Company:_____ Insurance Provider Phone #: _____

Member ID#: _____Group #: _____

Were you involved in a work related injury? ☐ YES ☐NO Date of Injury:_____

Were you involved in a motor vehicle accident? ☐YES ☐NO Date of Injury:_____

If "yes" on either Please fill out additional questionnaire

What is your chief complaint today? _____

_____

_____

When and how did your condition begin? (Date is required for some insurance) – Date of onset: _____

_____

Past or current treatment for condition? (Medications, surgery, injections, therapy, chiro, acu, diet etc.) _____

_____

Have you had imaging (X-rays, MRI), lab work or any other tests for this condition? What and when?_____

_____

Patient Name:_____ **Date:**_____

SYMPTOM RATING SCALE

Instructions: Please circle the number that best describes your symptoms in each of the questions below

What is your symptom intensity **RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

No Symptoms Unbearable Symptoms

What is your **TYPICAL or AVERAGE** symptom intensity?

0 1 2 3 4 5 6 7 8 9 10

No Symptoms Unbearable Symptoms

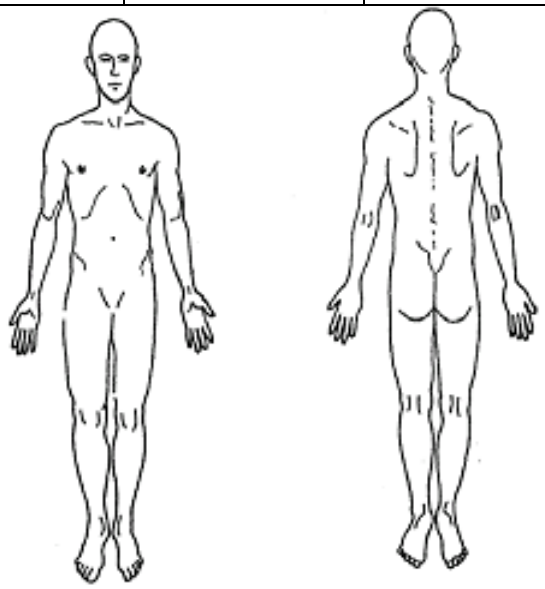
What is your symptom intensity **AT ITS WORST?**

0 1 2 3 4 5 6 7 8 9 10

No Symptoms Unbearable Symptoms

TELL US WHERE YOU'RE HURT: Mark the areas on your body where you feel pain. If your pain radiates, draw an arrow from where it starts to where it stops. Use the symbols listed below

ACHE	BURNING	NUMBNESS
>>>>>>	XXXXX	========
STABBING	PINS/NEEDLES	THROBBING
//////////	000000000	~~~~~~~~



How often are your symptoms present?

☐ Constantly ☐ Frequently ☐ Intermittently ☐ Rarely

Since it began, is your condition:

☐ improving ☐Getting Worse ☐No Change

Can you perform your daily activities?

☐ Yes ☐ Yes, with help ☐ Not at all

What makes the problem better?

☐ Nothing ☐ Lying Down ☐ Walking

☐ Standing ☐ Sitting ☐ Inactivity/Rest

☐ Exercise ☐ Movement ☐ Diet _____

☐ Medications _____ ☐ Other_____

What makes the problem worse?

☐ Nothing ☐ Lying Down ☐ Walking

☐ Standing ☐ Sitting ☐ Inactivity/Rest

☐ Exercise ☐ Movement ☐ Diet _____

☐ Medications _____ ☐ Other_____

Medical and Surgical History: Have you ever had any of the following? Circle any within the last year.

N	Y		N	Y		N	Y	
☐	☐	History of recent infection	☐	☐	Prostrate problems	☐	☐	Fever
☐	☐	Frequent urination	☐	☐	Corticosteroid use	☐	☐	HIV/AIDS
☐	☐	Pregnancy, # of births_____	☐	☐	Abnormal weight gain/loss	☐	☐	Arthritis
☐	☐	Epilepsy/Seizures	☐	☐	Surgery (date)_____	☐	☐	General Fatigue
☐	☐	High blood pressure	☐	☐	Heart attack (date)_____	☐	☐	Low back pain
☐	☐	Dizziness/fainting	☐	☐	Stroke (date)_____	☐	☐	Mid back pain
☐	☐	Numbness in groin/buttocks	☐	☐	Urinary retention	☐	☐	Neck pain
☐	☐	Aortic Aneurysm	☐	☐	Cancer/tumor_____	☐	☐	Osteoporosis
☐	☐	Visual disturbances	☐	☐	Diabetes	☐	☐	Hysterectomy
☐	☐	Ovaries removed	☐	☐	History of chemotherapy	☐	☐	Fractures
☐	☐	History of anti-seizure meds	☐	☐	Drug or Alcohol dependence	☐	☐	Irritable Colon
☐	☐	Metal implants/metal chards	☐	☐	Headache (type)_____	☐	☐	Thyroid condition

☐ ☐ Other (list any condition you feel we should know about)_____

Patient Name: _____ **Date:** _____

Please list any allergies (food, medications, environmental etc)

_____ _____

_____ _____

Please list any past surgeries, hospitalizations and/or traumas **Dates**

_____ _____

_____ _____

_____ _____

Please list all prescription medications that you are taking (including dosage)

_____ _____

_____ _____

Please list all non-prescription medications, vitamins or herbs that you are taking

_____ _____

_____ _____

Family history (Parents/Siblings only):

☐ Cancer ☐Diabetes ☐ Heart Attack ☐ Chronic Headache ☐ Arthritis ☐ High Blood Pressure

☐ Back or Disk problems ☐ Thyroid disease ☐Stroke ☐Other_____

Health Habits:

Date of last physical examination? _____Any abnormal findings? _____

Do you eat a special diet? ☐YES ☐NO if "yes" please describe _____

Do you exercise regularly? ☐YES ☐NO if "yes" how many times/week _____

What kinds of exercise to you do?_____

Do you smoke? ☐YES ☐NO if "yes" what and how much? _____

Have you ever smoked? ☐YES ☐NO if "yes" when did you stop? _____

Do you chew tobacco? ☐YES ☐NO if "yes" what and how much? _____

Do you drink alcohol? ☐YES ☐NO if "yes" what and how much? _____

Women ONLY

☐YES ☐NO Abnormal vaginal or menstrual bleeding

☐YES ☐NO Taking birth control pills or estrogen

Men and Women

☐YES ☐NO Breast lumps or nipple discharge

☐YES ☐NO Do you do a monthly self breast exam?

Men ONLY

☐YES ☐NO Regular prostate (>50 age) exam

☐YES ☐NO Regular testicular (<40 age) exam

☐YES ☐NO Abnormal penile discharge

I certify that the above information is complete and accurate. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

_____ _____

Patient or Guardians Signature **Date**