Patient Intake Form

Name: ____________________________________
Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino
Preferred Language ____

Are your present problems due to an injury? ?Yes ?No Enter the date of the injury:
____
Was the injury? ? Job Related ?Auto Accident ?Personal Injury ?Other:
Has the accident been reported? ?Yes ?No If so, to whom? ?To Employer ?Auto Carrier ?Other:
Briefly describe the accident, injury or illness:

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom
______________________________________ ?(1) Very Mild ?(2) ?(3) ?(4) ?(5) ?(6) ?(7) ?(8) ?(9) ?(10) Remarkably Severe
______________________________________ ?(1) Very Mild ?(2) ?(3) ?(4) ?(5) ?(6) ?(7) ?(8) ?(9) ?(10) Remarkably Severe
______________________________________ ?(1) Very Mild ?(2) ?(3) ?(4) ?(5) ?(6) ?(7) ?(8) ?(9) ?(10) Remarkably Severe
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______________________________________ ?(1) Very Mild ?(2) ?(3) ?(4) ?(5) ?(6) ?(7) ?(8) ?(9) ?(10) Remarkably Severe
List any tests, studies or medications received for this condition:
?Tests/Studies:
?Medications:
Where you admitted to the hospital due to this condition: ?Yes ?No
If yes, what hospital? ______________________Transported by? ?Ambulance ?Police ?Other:
____
Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________
List the hospital procedures received:
____
List symptoms you are experiencing today: Choose the severity level associated with each symptom
______________________________________ ?(1) Very Mild ?(2) ?(3) ?(4) ?(5) ?(6) ?(7) ?(8) ?(9) ?(10) Remarkably Severe
______________________________________ ?(1) Very Mild ?(2) ?(3) ?(4) ?(5) ?(6) ?(7) ?(8) ?(9) ?(10) Remarkably Severe
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Severe

Do you have any current work restrictions due to this condition?
Off work: ?Yes ?No ?Previously From: To:
Light duty: ?Yes ?No ?Previously (If yes, what are/were your restrictions?)
What type of work do you do?

Do you suffer from any condition other than that for which you are now consulting us? ?Yes ?No

_____

_____

List any past conditions you may have had:

_____

HABITS

?Current Every Day Smoker ?Current Some Day Smoker
?Former Smoker ?Never Smoker
?Drinking Alcohol: (Cups/day): _____ ?Coffee Cups/Day: _____
?Soft Drink Bottles or Cans/Day: _____ ?Water Cups/Day: _____

EXERCISE FAMILY HISTORY
?None Diabetes Cancer Back Pain Other
?Moderate Mother ????????????
?Daily Father ????????????
Sibling(s) ????????? ?

Are you taking any medication (prescription or over-the-counter)? ?Yes ?No
If Yes, please indicate the following:

Medication: _____ Medication:

_____

Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency:

_____

Began Use: _____ Began Use:

_____

Discontinued Use: _____ Discontinued Use:

_____

Medication: _____ Medication: _____

Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other:

_____

Frequency: _____ Frequency:

_____

Began Use: _____ Began Use:

_____

Discontinued Use: _____ Discontinued Use:

_____

_____ _____

Have you taken any medications in the past? ?Yes ?No If yes, which ones?:

Do you have allergies to medication? ?Yes ?No
If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ?Yes ?No (If yes, please enter the approximate date of surgery.)
DATE DATE
DATE
Back Operation Hernia Gall Bladder Female Organs Thyroid Stomach
Other
Have you ever had X-rays taken? ?Yes ?No When? By Whom?
For what ailments were these X-rays taken?
OPERATIONS AND PROCEDURES
Please check the box for each current or past symptom listed.

EYE/EAR
GENERAL SYMPTOMS GASTRO-INTESTINAL NOSE/THROAT
RESPIRATORY

? Allergy(What) ____ ? Belching or Gas ? Asthma ? Chest Pain
_____ ? Colon Trouble ? Deafness ? Chronic Cough
? Bronchitis ? Constipation ? Earache ? Difficulty
Breathing
? Chills (Constant) ? Diarrhea ? Ear Discharge ? Spitting Blood
? Convulsions ? Gall Bladder Trouble ? Ear Noises ? Spitting Phlegm
? Dizziness ? Hemorrhoids (piles) ? Thyroid Problems
? Fainting ? Jaundice ? Frequent Colds
GENITO-URINARY
? Fatigue ? Liver Trouble ? Hay Fever ? Bed Wetting
? Headache ? Nausea ? Nasal Obstruction ? Blood in
Urine
? Loss of Sleep ? Stomach Pain ? Nose Bleeds ? Frequent
Urination
? Loss of Weight ? Vomiting ? Pain in Eyes ? Inability
to Control
? Nervousness ? Vomiting Blood ? Poor Vision ??Urine
? Night Sweats ? Heart Burn ? Blurred Vision ? Kidney
Infection
? Numbness or Pain ? Bloody Stools ? Sinusitis ? Kidney
Stones
in arms/legs/hands ? Acid Reflux ? Sore Throats ? Painful
Urination
? Wheezing ? Irritable Bowel ? Tonsillitis ? Prostate
Trouble

MUSCLES & JOINTS CARDIO-VASCULAR SKIN OR ALLERGIES
FOR FEMALES ONLY
? Backache ? High Blood Pressure ? Bruising Easily ? Cramps
? Foot Trouble ? Low Blood Pressure ? Dryness ? Hot

Flashes
? Hernia ? Chest Pain ? Eczema ? Irregular Cycle
? Pain Between Shoulders ? Heart Trouble ? Hives or Allergy ? Painful Periods ? Poor Circulation ? Itching ? Vaginal Discharge
? Painful Tail Bone ? Rapid Heart ? Sensitive Skin ? Pregnant Now?
? Stiff Neck ? Slow Heart ? Skin Eruptions _____ Last Pap Date
? Spinal Curvature ? Strokes
_____ Last Menstrual Cycle
? Swollen Joints ? Swelling Ankles
? Tremors ? Varicose Veins

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
?Appendicitis ?Anemia ?Heart Disease ?Arthritis ?Pneumonia ?Measles ?Goiter ?Epilepsy ?Rheumatic Fever ?Mumps ?Influenza ?Mental Disorder
?Polio ?Chicken Pox ?Pleurisy ?Lumbago ?Tuberculosis ? Diabetes
?Alcoholism ?Eczema ?Whooping Cough ?Cancer ?Venereal Disease ?HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____