Patient Intake Form

Date:_____

Name:_____

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

Circle: Male Female Married Single Widowed Divorced Separated

Birth Date: _____ Age:_____ Email Address:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Occupation:_____ Work Phone:_____

Business Address:_____ City:_____ State:_____

Spouse/Guardian Name:_____ Phone #:_____

Emergency Contact:_____ Phone #:_____

Whom may we thank for referring you to us? _____

Do you have **Medicare** Insurance: NO YES If Yes, **Medicare ID #**_____

Symptoms

Main Complaint:_____ How often?_____ Getting worse? Y N

When did it start?_____ What activity bothers it most? _____

When does it bother you least?_____ Most?_____

How is the quality of life affected by this issue? _____

Rate the pain: (0 = pain-free, 10 = unbearable) 0 1 2 3 4 5 6 7 8 9 10

Rate your frustration dealing with this issue: 0 1 2 3 4 5 6 7 8 9 10

How serious would you rate this issue? (Circle one) Slight Moderate Severe

Rate your motivation to resolve this issue: Slight Moderate Severe

Have you seen other Chiropractors? Yes No When?_____ Positive Experience? Yes No

Other type of treatment? Yes No What?: _____ Positive? Yes No

Secondary Complaint: _____

Health History - Please circle **ALL** that apply

AIDS/HIV	Allergy shots	Anemia	Anorexia	Appendicitis	Asthma
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Depression
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gout
Hepatitis	Hernia	Herniated Disc	Herpes	Hi Cholesterol	Liver Disease
Migraines	Mono	M.S.	Mumps	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate	Prosthesis	Implants	Stroke
Tonsillitis	Tuberculosis	Ulcers	Bleeding	Heart Disease	Measles
Whooping Cough	Chronic Fatigue	Hi Blood Pressure	Thyroid	Fibromyalgia	Diabetes

Are you pregnant? Yes No If yes, due date?: _____

Previous surgeries and dates: _____

_____

List and Injuries/Falls within the last year_____

List ALL Medications you are taking_____

_____

What kind of exercise do you do?:_____

How much do you smoke per day?:_____ Drinks per week?:_____

***All of the above questions have been answered correctly and to the best of my knowledge; I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party or other healthcare providers.