Patient Intake Information

Date_____ Patient Number_____

_____

First Name MI Last Name Date Of Birth Age

Street_____ City_____ State_____ Zip_____

Social Security #_____ Marital Status: ( )S ( )M ( )W ( )D Spouse_____

Occupation:_____ Employer_____Phone#_____

Contact Info: Home Ph:_____ Cell Ph:_____

Cell Phone Carrier_____ Best time to call_____

Email:_____Contact Preference:__Home Ph __Work Ph__Cell Ph __Email

Emergency Contact:_____ Phone:_____

Language: __English __Spanish __Indian __Japanese __French __German __Korean Other_____

Race/Ethnicity: __Caucasian __American Indian/Alaska Native __Asian __Hispanic/Latino

__Black/African American __Native Hawaiian/Other Pacific Islander __Decline to Answer

Who referred you to our office?_____

Alcohol use__Past __Present __Never **Smoker**__Past __Present __Never **Drug use**__Past __Present__Never

Allergies/Reactions_____

Illnesses (Diabetes, High Blood Pressure, Etc.)_____

Hospitalizations/Surgeries_____

_____

Current Medications/Dosage(Include over the counter products/vitamins)_____

_____

Family Health **List Major Illness or Cause of Death**

Alive/Deceased Mother_____ Alive/Deceased Father_____

Alive/Deceased Sister_____Alive/Deceased Brother_____

It is usual and customary to pay for services rendered unless otherwise arranged.

BP_____ Pulse_____ Ht_____ Wt_____ **(Office Use Only)**

Patient Health Questionnaire

Patient Name_____**Date**_____ **Patient Number**_____

Describe your current symptoms (Begin with what bothers you most)_____

_____

When did your symptoms begin?_____

What activities make your symptoms worse?

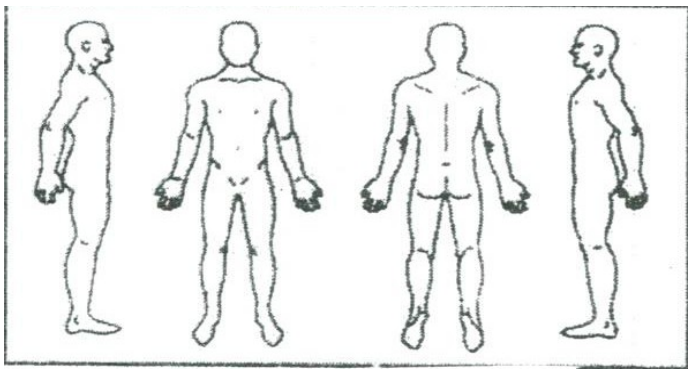
__Ice __Rest __Sitting __Medication __Heat __Activity __Standing __Other

What activities make your symptoms better?

__Ice __Rest __Sitting __Medication __Heat __Activity __Standing __Other

What describes the nature of your symptoms? __Sharp __Numb __Dull Ache __Shooting __Burning __Tingling

Indicate where you have pain or other symptoms.



What describes the severity of your symptoms?

None 1 2 3 4 5 6 7 8 9 10 Severe

How are your symptoms changing? __Getting Better

__Not Changing

__Getting Worse

Who else have you seen for your symptoms? __ No One __Chiropractor __Medical Doctor __Physical Therapist __Other

What test have you had for your symptoms? None____

X-rays Date_____ MRI Date_____ CT Scan Date_____ Other Date_____

What other forms of care have you tried for your current complaint? __ Nothing

__Muscle Relaxer __Advil/Tylenol/Aleve, etc __Injections __Pain Medication __Ice/Heat __Physical Therapy __Other

What do you feel caused your symptoms? __Fall __Car Accident __Lifting __Don't Know __Work __ Other_____

What activities are affected by your symptoms?

__Work/School __Sleeping __Drive/Riding in Car __Golf __Exercise

__Walking __Running __Housework __Yard Work __Other_____

Have you had similar symptoms in the past? __ Yes When?_____ __No

If yes whom did you see? __ No One __Chiropractor __Medical Doctor __Physical Therapist __Other

What is your regular exercise type? __None __Light __Moderate __Heavy

Patient Name_____**Date**_____ **Patient Number**_____

For each of the conditions listed below, place a check in the **PAST** column if you have had the condition in the past.

If you have the conditions listed, place a check in the **PRESENT** column.

Many of the following conditions respond to chiropractic and acupuncture

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
___	___	Headaches	___	___	High Blood Pressure	___	___	Diabetes
___	___	Neck Pain	___	___	Heart Attack	___	___	Excessive Thirst/Urination
___	___	Upper Back Pain	___	___	Chest Pains	___	___	Thyroid Disorder
___	___	Mid Back Pain	___	___	Stroke			
___	___	Low Back Pain	___	___	Angina	___	___	Smoking/Tobacco Use
						___	___	Drug/Alcohol Dependence
___	___	Shoulder Pain	___	___	Kidney Stones			
___	___	Elbow/Upper Arm Pain	___	___	Kidney Disorder	___	___	Depression
___	___	Wrist Pain	___	___	Bladder Infection	___	___	Frequent Illness
___	___	Hand Pain	___	___	Painful Urination	___	___	Epilepsy
			___	___	Loss of Bladder Control	___	___	Dermatitis/Eczema/Rash
___	___	Hip/Upper Leg Pain	___	___	Prostrate Problems			
___	___	Knee/Lower Leg Pain						
___	___	Ankle/Foot Pain	___	___	Abnormal Weight Gain/Loss		**Females Only**	
			___	___	Loss of Appetite	___	___	Hot Flashes
___	___	Jaw Pain/TMJ	___	___	Abdominal Pain	___	___	Hormone Replacement
			___	___	Ulcer	___	___	Birth Control Pills
___	___	Joint Stiffness	___	___	Hepatitis	___	___	Painful Periods/Cramps
___	___	Arthritis	___	___	Rheumatoid Arthritis	YES	NO	Are you pregnant?
___	___	Liver/Gall Bladder Disorder				Estimated Due Date_____		
			___	___	Cancer		**Other Health Problems**	
___	___	General Fatigue	___	___	Tumor	___	___	_____
___	___	Ringing in Ears	___	___	Asthma	___	___	_____
___	___	Visual Disturbances	___	___	Chronic Sinusitis	___	___	_____
___	___	Dizziness	___	___	Seasonal Allergies			

Detail of any history of trauma to head, neck, or back(automobile accidents, sports injuries, work-related accidents, etc.):

_____

_____

Primary Care Physician_____ **Date of Last Medical Physical**_____

_____

Patient Signature_____ **Date**_____