Patient Intake Form

For Office Use Only
Date: ____________________
Acct #: ____________________

Name: ______________________________________

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

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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

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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

❑Smoking Packs/day: _____

❑Drinking Alcohol: (Cups/day): _____

❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____

❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑_____
Father	❑	❑	❑	❑_____
Brother(s)	❑	❑	❑	❑_____
Sister(s)	❑	❑	❑	❑_____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? ❑Yes ❑No
If yes, which ones?: _____

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

Do you have allergies? ❑Yes ❑No If yes, please explain: _____

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.

GENERAL SYMPTOMS

❑ Allergy(What) ____

_____

❑ Bronchitis

❑ Chills (Constant)

❑ Convulsions

❑ Dizziness

❑ Fainting

❑ Fatigue

❑ Headache

GASTRO-INTESTINAL

❑ Belching or Gas

❑ Colon Trouble

❑ Constipation

❑ Diarrhea

❑ Gall Bladder Trouble

❑ Hemorrhoids (piles)

❑ Jaundice

❑ Liver Trouble

❑ Nausea

EYE/EAR NOSE/THROAT

❑ Asthma

❑ Deafness

❑ Earache

❑ Ear Discharge

❑ Ear Noises

❑ Thyroid Problems

❑ Frequent Colds

❑ Hay Fever

❑ Nasal Obstruction

RESPIRATORY

❑ Chest Pain

❑ Chronic Cough

❑ Difficulty Breathing

❑ Spitting Blood

❑ Spitting Phlegm

GENITO-URINARY

❑ Bed Wetting

❑ Blood in Urine

EYE/EAR

GENERAL SYMPTOMS	GASTRO-INTESTINAL	NOSE/THROAT	GENITO-URINARY
❑ Loss of Sleep	❑ Stomach Pain	❑ Nose Bleeds	❑ Frequent Urination
❑ Loss of Weight	❑ Vomiting	❑ Pain in Eyes	❑ Inability to Control Urine
❑ Nervousness	❑ Vomiting Blood	❑ Poor Vision	❑ Kidney Infection
❑ Night Sweats	❑ Heart Burn	❑ Blurred Vision	❑ Kidney Stones
❑ Numbness or Pain in arms/legs/hands	❑ Bloody Stools	❑ Sinusitis	❑ Painful Urination
❑ Wheezing	❑ Acid Reflux	❑ Sore Throats	❑ Prostate Trouble
	❑ Irritable Bowel	❑ Tonsillitis	

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
❑ Painful Tail Bone	❑ Poor Circulation	❑ Itching	❑ Vaginal Discharge
❑ Stiff Neck	❑ Rapid Heart	❑ Sensitive Skin	❑ Pregnant Now?
❑ Spinal Curvature	❑ Slow Heart	❑ Skin Eruptions	_____ Last Pap Date
❑ Swollen Joints	❑ Strokes		_____ Last Menstrual Cycle
❑ Tremors	❑ Swelling Ankles		
❑ Twitching	❑ 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: _____