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		**EXERCISE**	**FAMILY HISTORY**	Diabetes	Cancer	Back Pain	Other
❑Smoking	Packs/day: _____	❑None					
❑Drinking	Alcohol: (Cups/day): _____	❑Moderate	Mother	❑	❑	❑	❑________
❑Coffee	Cups/Day: _______	❑Daily	Father	❑	❑	❑	❑________
❑Soft Drink	Bottles or Cans/Day: _____	Type: _________	Brother(s)	❑	❑	❑	❑________
❑Water	Cups/Day: _______	______________	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	**GASTRO-INTESTINAL**	**EYE/EAR 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

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

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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: ______________________