Intake Form

Name: _____ Sex: M F Date:_____

Address: _____City:_____ State:_____ Zip: _____

Date of Birth: _____ Age: _____

Phone Home:_____ Cell: _____ Work:_____

Social Security Number: _____ Email: _____

Occupation: _____ Employer: _____

How did you hear about our clinic? _____

Marital Status: _____Spouse name: _____

Spouse date of birth: _____Spouse Employer: _____

Have you ever had chiropractic care in the past: Yes No When:_____

Insurance Coverage

1. Primary Insurance Company Name:_____

Insurance ID number:_____ Group Number:_____

Primary Insured:_____

2. Secondary Insurance Company Name:_____

Insurance ID number:_____ Group Number:_____

Primary Insured:_____

Claim number (auto accident or work comp):_____

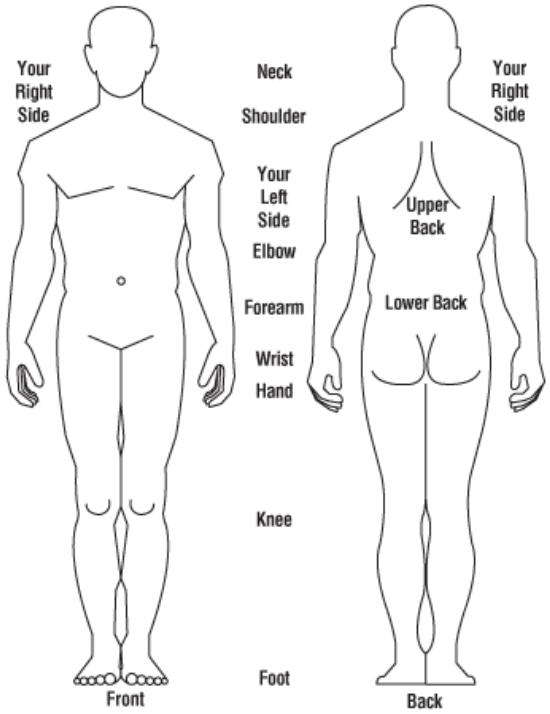
Claims Contact Person (auto or work comp):_____

Insurance Phone Number:_____Location:_____

Lawyer Name: _____ Lawyer Phone:_____

Law Firm Location:_____

Name: Date:



Please label drawing with location of pain

Current Complaint #1:
Location of complaint:

_____

Describe the onset of the complaint:

_____

_____

_____

Describe the pain:
aching burning dull sharp shooting throbbing deep boring nagging other:_____

Have you seen any other providers for this complaint? If so please list:_____

Current Complaint #2:
Location of complaint:

_____

Describe the onset of the complaint:

_____

_____

Describe the pain: aching burning dull sharp shooting throbbing deep boring nagging other: _____

Have you seen any other providers for this complaint? If so please list:_____

Current Complaint #3:

Location of complaint:

_____

Describe the onset of the complaint:

_____

_____

Describe the pain: aching burning dull sharp shooting throbbing deep boring nagging other: _____

Have you seen any other providers for this complaint? If so please list:_____

Name: Date:

Medical or Health Care Providers:

1. Name_____ Phone Number: _____Location:_____

2. Name_____ Phone Number: _____Location:_____

3. Name_____ Phone Number: _____Location:_____

4. Name_____ Phone Number: _____Location:_____

5. Name_____ Phone Number: _____Location:_____

Previous Trauma: please list any prior motor vehicle accidents, broken bones, or any other bodily trauma

Trauma: _____ Date:_____

Trauma: _____ Date:_____

Trauma: _____ Date:_____

Trauma: _____ Date:_____

Trauma: _____ Date:_____

Medical Conditions:

Are you being treated for any other medical conditions? If so please list below

_____

_____

Medication List: please list all medications, vitamins, or supplements below

1._____2._____

3._____4._____

5._____6._____

7._____8._____

9._____10._____

Gynecological History:

Is there any chance you are pregnant? Yes No

Females please list pregnancies, gynecological procedures, or ongoing female complaints

_____

Name: Date:

Review of Systems: please circle if you or a member of your family has had any of the following
(S= self, M=Mother, F=Father, B=Brother, S=Sister, G=Grandparent)

Fatigue **S M F B S G**
Insomnia **S M F B S G**
Sleep Apnea **S M F B S G**
Fever (current) **S**
Unexplained weight loss **S**
Unexplained weight gain **S**
Night sweats **S**
Cancer **S M F B S G**
Headache **S M F B S G**
Migraine headache **S M F B S G**
Dizziness **S**
Vertigo **S**
Loss of Balance **S**
Room Spinning **S**
Hot flashes **S**
Neck pain **S**
Eye pain **S**
Ringing in the ears (tinnitus) **S**
Ear infections **S**
Recurrent sinus infections **S**
Loss of smell **S**
Heart disease **S M F B S G**
Heart attack **S M F B S G**
Stroke **S M F B S G**
High blood pressure **S M F B S G**
Other heart condition _____ **S M F B S G**
Plaque in arteries **S M F B S G**
Swollen ankles **S**
Cold extremities **S**
Varicose Veins **S**
Hemorrhoids **S**
Shortness of breath **S**
Chest pain **S**
COPD **S M F B S G**
Asthma **S M F B S G**
Acid Reflux **S M F B S G**
Constipation **S**
Irritable bowel **S M F B S G**
Inability to hold bowels **S**
Digestion problems **S M F B S G**
Ulcerative Colitis **S M F B S G**

Crohn's Disease **S M F B S G**
Gastrointestinal problem _____ **S M F B S G**
Kidney Infection **S**
Recurrent bladder infection **S**
Kidney stones **S**
Frequent urination **S**
Inability to hold urine **S**
Painful menstruation **S**
Excessive flow **S**
Irregular cycle **S**
Menopause **S**
Prostate trouble **S**
Benign prostatic hypertrophy **S**
Back pain **S M F B S G**
Spondylolisthesis **S M F B S G**
Ankylosing Spondylitis **S M F B S G**
Scoliosis **S M F B S G**
Intervertebral Disc Injury **S M F B S G**
Rash (current) **S**
Eczema **S M F B S G**
Psoriasis **S M F B S G**
Lupus **S M F B S G**
Pitting nails **S**
Bruising (current) **S**
Scleroderma **S M F B S G**
Pain in arms **S**
Pain in legs **S**
Numbness and tingling **S**
Diplopia (double vision) **S**
Nausea (current) **S**
Trouble talking (current) **S**
Depression **S M F B S G**
Anxiety **S M F B S G**
Psychiatric disorder_____ **S M F B S G**
Diabetes **S M F B S G**
Hyperthyroid (high) **S M F B S G**
Hypothyroid (low) **S M F B S G**
Hormone imbalances _____ **S M F B S G**
Bruise easily **S**
Anemia **S**
Blood disorder _____ **S M F B S G**

Name: Date:

Surgical History: Please list all surgeries below

Procedure: _____ Date:_____

Procedure: _____ Date:_____

Procedure: _____ Date:_____

Procedure: _____ Date:_____

Procedure: _____ Date:_____

Do you smoke or use tobacco products? Yes No

Have you ever used tobacco products? Yes No

Do you have pain every day? Yes No

Does pain wake you from sleep? Yes No

Patient
Signature_____ Date:_____

Name: Date: