Patient Intake Form

For Office Use Only
Date: ____________________
Acct #: ____________________
Patient Height ____________
Patient Weight ____________
Patient BMI ____________
Patient Blood Pressure ________

Name: ______________________________________

Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino

Preferred Language ______________________________________

Where is your primary complaint?______________________________________

Where is your secondary complaint? ______________________________________

What were you doing when the pain started?______________________________________

When did the pain start? Date______________________________________

What does this prevent you from doing or enjoying?______________________________________

Is the pain getting worse? ___Yes ___No ___Same ___ Better ___Can't Tell Other______________

How frequent is the pain? ___Constant ___Frequent ___ Intermittent ___Night Only Other____________

Describe the pain: ___Sharp ___Shooting ___ Stabbing ___Aching ___Numbness ___Tingling ___Burning ___Dull

What makes the pain worse? ___Standing ___Sitting ___Sitting ___Lying ___Bending ___Lifting ___Twisting ___Walking ___ Looking up Other ______________________________________

What makes the pain better? ___Standing ___Sitting ___Lying ___Bending ___Lifting ___ Twisting ___Walking Other______________________________________

Does the pain wake you up at night? ___Yes ___No

Has there been recent unexpected weight loss? ______________________________________

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:	Choose the severity level associated with each symptom (see Mankoski Pain Scale)
____________________	❑(1) ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10)
____________________	❑(1) ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10)
____________________	❑(1) ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10)
____________________	❑(1) ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10)
____________________	❑(1) ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10)

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: _____

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

❑Current Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____

Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

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 Imaging (X-rays, MRI, etc) taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these tests 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
- ❑ Loss of Sleep
- ❑ Loss of Weight

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control

- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

Urine

- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Herniated disc
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?
- _____ Last Pap Date
- _____ Last Menstrual Cycle

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:** _____

PATIENT DATA SHEET

General Information

First Name _____
Middle Initial _____
Last Name _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Pager No. _____
Email Address _____
Sex Male Female
Race American Indian, Alaska Native, Asian, Black or African America, Native Hawaiian, Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino, Not Hispanic or Latino
Language _____
Marital Status Single Married Other _____
Birthdate _____
Social Security _____
Referred By _____
Work Status Employed Full-time student Part-time student
Appt Reminder _____

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____

For Office Use Only

Account Number _____
Account Category _____
Type of Account 1 2 3 4 5 6 7 8 9 Z
Code Set _____
Yearly Deductible _____
Deductible Rest Date _____
Unused Deductible _____
Copay _____
Patient Percentage _____
Household Mailing Yes No
Doctor Number _____
Maximum Charges _____
Max Charge per Day _____
Maximum Visits _____
Max Visits Since Diag _____
Max Treatment Date _____
Full Balance _____
Patient Balance _____
Diagnosis Codes _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Benefits Primary Secondary Other
Coordination _____
Send Form To _____
Claim Type _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

Condition Information

Related to Employment Yes No
Related to Auto Accident Yes No
Related to Other Accident Yes No
Similar Symptoms _____
Consultation Date _____
Condition Date _____