Chiropractic Partners

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NEW PATIENT INTAKE

DATE: _____ HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FULL, LEGAL NAME: _____ GENDER: M___ F ___

BIRTHDATE: _____/_____/_____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (C) _____ (W) _____ (H) _____

EMAIL ADDRESS _____

Employer and Occupation: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED WIDOWED DIVORCED OTHER

Emergency contact and phone number: _____

SYMPTOMS ASSESSMENT

WHAT ARE YOUR PRIMARY COMPLAINTS? _____

_____

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? Yes No.

When? _____

Is the Condition (circle): Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause

Other, please explain: _____

_____

Date of Accident: _____ Time of Accident: _____ am /pm

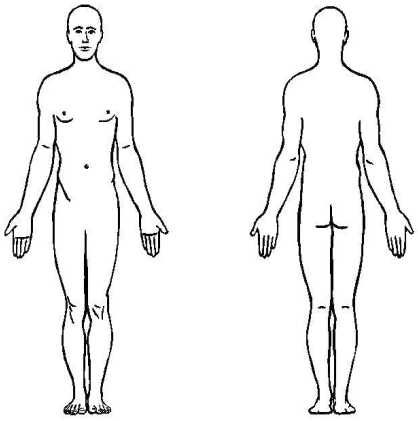
Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER condition than which you are now consulting us? _____

_____

Please Label On The Diagram The Area Of Discomfort

Use the letters BELOW to indicate the TYPE and LOCATION of



Rate your pain level. 0-10 Scale 0 being no pain, 10 being severe pain.

Active 0 1 2 3 4 5 6 7 8 9 10 Resting 0 1 2 3 4 5 6 7 8 9 10

Current Height _____ Current Weight _____

WHAT ACTIONS AGGRAVATE YOUR SYMPTOMS? _____
WHAT ACTIONS RELIEVE YOUR SYMPTOMS? _____

LIST ANY ACTIVITIES OF YOUR DAILY LIVING THAT ARE YOU UNABLE TO PERFORM DUE TO YOUR CURRENT CONDITION:_____
HAVE YOU BEEN TREATED FOR THIS CONDITION BY ANY OTHER DOCTOR (CIRCLE ONE)? YES NO
IF YES, PLEASE SPECIFY DOCTOR, DATE, AND TREATMENT: _____

SYSTEMS REVIEW

SINCE YOUR SYMPTOMS BEGAN, ARE THEY (CIRCLE ONE): BETTER WORSE THE SAME

PLEASE CIRCLE ANY SYMPTOMS THAT YOU HAVE HAD WITHIN THE LAST 6 MONTHS: DIZZINESS

HEART PALPATATIONS BREAST LUMPS PAINFUL URINATION PROSTATE PROBLEM CHEST PAIN

MEDICAL HISTORY

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE BEFORE (CIRCLE ONE)? YES NO

HAVE YOU EVER BEEN HOSPITALIZED (CIRCLE ONE)? YES NO
IF YES, PLEASE SPECIFY DATE AND REASON: _____

HAVE YOU EVER HAD SURGERY (CIRCLE ONE)? YES NO
IF YES, PLEASE SPECIFY DATE AND REASON: _____
_____

HAVE YOU EVER HAD ANY ACCIDENTS (CIRCLE ONE)? YES NO
IF YES, PLEASE SPECIFY: AUTO_____ WORK _____ OTHER _____ DATE _____
DESCRIBE ACCIDENT: _____

ARE YOU CURRENTLY TAKING MEDICATION (CIRCLE ONE)? YES NO
IF YES, LIST MEDICATION AND CONDITION PRESCRIBED FOR: _____
_____

PLEASE CHECK ANY OF THE FOLLOWING ILLNESSES THAT YOU NOW HAVE, HAVE HAD IN THE PAST, OR ANYONE IN YOUR FAMILY HAS (CIRCLE ALL THAT APPLY):

DIABETES HEART TROUBLE HIGH BLOOD PRESSURE SPINAL DISC DISEASE SCOLIOSIS PROSTATE TROUBLE
**PLEASE DESCRIBE AND SPECIFY ANY ILLNESSES : _____
_____

WOMEN ONLY
TO YOUR KNOWLEDGE, ARE YOU PREGNANT (CIRCLE ONE)? YES NO

INSURANCE INFORMATION

COPIES OF APPLICABLE INSURANCE CARDS NEED TO BE KEPT ON FILE FOR PROPER PROCESSING

ARE YOU INSURED BY ANOTHER PERSON'S PLAN (SPOUSE) (CIRCLE ONE)? YES NO
IF YES, PLEASE FILL IN THE FOLLOWING INFORMATION ABOUT YOUR SPOUSE:

FULL NAME: _____ BIRTHDATE: _____/_____/_____

EMPLOYER: _____

PATIENT SIGNATURE _____