ACHIEVE
CHIROPRACTIC CARE

New Patient Intake

Date:

Patient Information

Name: _____ **Date of Birth:** _____ **Age:** _____

Preferred Name: _____ **Gender:** _____ **Prefix/Title:** _____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Email Address:** _____

Preferred Phone: _____ ☐ Mobile ☐ Home ☐ Work

Secondary Phone: _____ ☐ Mobile ☐ Home ☐ Work

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: _____ **Relation:** _____ **Phone Number:** _____

Occupation: _____ **Employer:** _____

Family Doctor: _____ **Doctor's Phone Number:** _____

Referral

Were you referred to our clinic by another physician? If so, whom? _____

If not, how did you hear about us? ☐ Google ☐ Facebook ☐ www.forwardthinkingchiro.com ☐ OB/GYN

☐ Doula/Midwife ☐ Friend or Family _____ ☐ Other _____

Insurance & Payment

Achieve Chiropractic Care is an out-of-network provider for all major health insurance plans.

If you have chiropractic coverage through your health insurance company, you can still use your benefits. Our office will supply you with a detailed receipt, upon request, that you can submit to your insurance for direct reimbursement.

We accept all major credit cards and Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA).

VISA MasterCard AMERICAN EXPRESS DISCOVER JCB UnionPay 银联

Payment is due at time of service.

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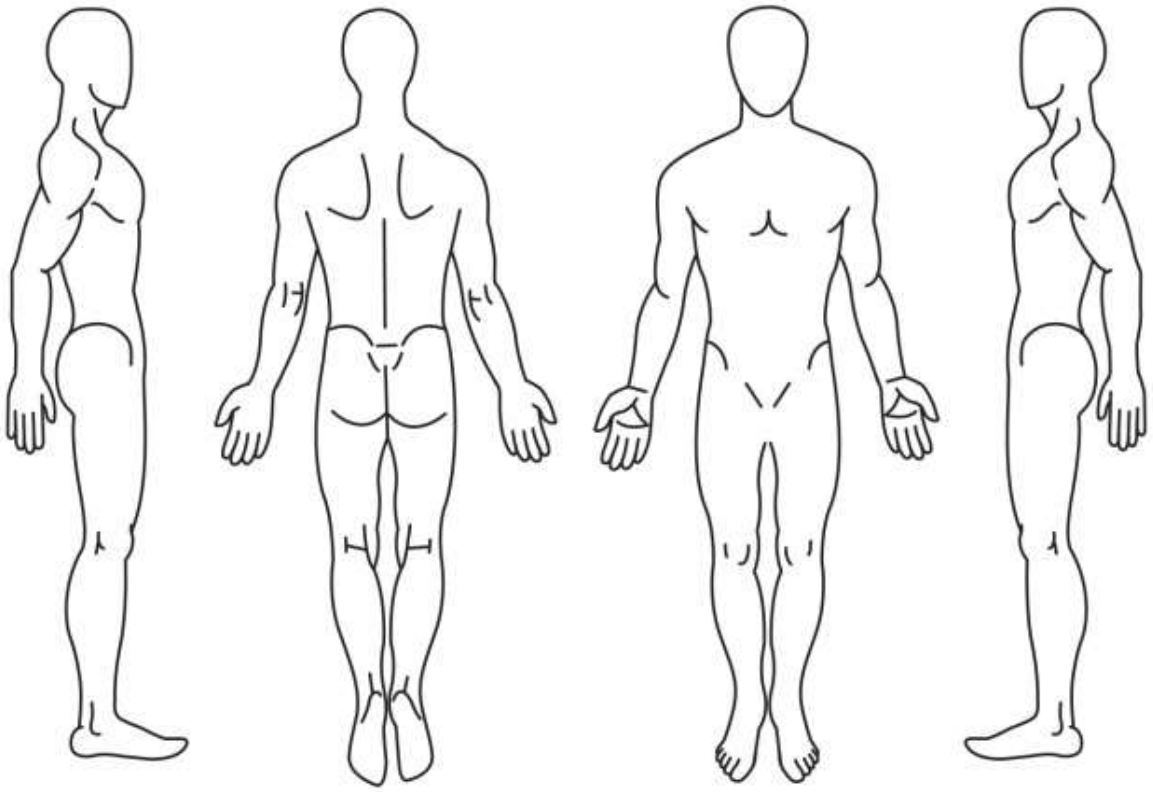
Current Health Conditions

Use the diagram below to indicate the type and location of your pain. Use the letters that best describe the pain:



P = pins & needles

N = numbness

S = stabbing

B = burning

A = dull ache

Please list your complaints in order from most bothersome or painful (1) to least (5).

1. _____
2. _____
3. _____
4. _____
5. _____

Check all of the following that describe your pain:

☐ Aching	☐ Hot/burning	☐ Shooting	☐ Sharp/stabbing
☐ Cramping	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Dull	☐ Deep	☐ Squeezing	☐ Pins & Needles

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent (off and on)

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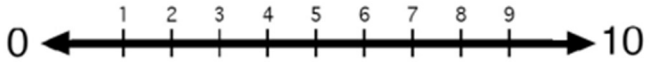
Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **average pain over the last month**? _____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improving ☐ Worsening ☐ Same

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ☐ Yes ☐ No

When is your pain at its worst? ☐ Mornings ☐ Day ☐ Evening ☐ Night

Pain Treatment History

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Please select any of the treatments you have tried to address your complaint:

- ☐ Hot Pack
- ☐ Cold Pack
- ☐ Rest
- ☐ Compression/Bracing
- ☐ Stretching
- ☐ Massage
- ☐ Medical Doctor
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Topical Pain Reliever
- ☐ OTC Medication
- ☐ Prescription Medication
- ☐ Injections
- ☐ Surgery
- ☐ Other

What makes your pain better? _____

What makes your pain worse? _____

Chiropractic History

Have you ever visited a Chiropractor before? ☐ Yes ☐ No **If yes, describe a typical treatment with your previous Chiropractor:**

_____

_____

What would you like to gain from Chiropractic care?

- ☐ Reduced Pain
- ☐ Restored Function
- ☐ Improved Performance
- ☐ Overall Wellness

Do you have any specific health goals you would like to accomplish (e.g. running a marathon, playing with your kids without pain, hitting a new weight lifting PR, sleeping 8 hours, etc.)?

_____

_____

Health History

Indicate if YOU or any of your IMMEDIATE FAMILY members have any of the following:

- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Lupus
- ☐ Thyroid Issues

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Health History (continued)

Mark any of the conditions or symptoms that you are currently experiencing or have experienced in the last year:

Constitutional

- ☐ Chills
- ☐ Fevers
- ☐ Night Sweats
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Insomnia
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Insomnia
- ☐ Unexplained Weight Gain/Loss
- ☐ Low Sex Drive
- ☐ Weakness
- ☐ Sensitivity to Light
- ☐ Head Injury/Concussion
- ☐ Cold Hands/Feet

Eyes/Ears/Nose/Throat

- ☐ Glasses/Contacts
- ☐ Recent Vision Changes
- ☐ Nosebleeds
- ☐ Recurrent Sore Throats
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Allergies

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath with Exertion
- ☐ Shortness of Breath at Rest

Cardiovascular

- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Deep Vein Thrombosis
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Irregular Heartbeat
- ☐ Shortness of Breath
- ☐ Swelling in Feet

Gastrointestinal

- ☐ Abdominal Pain/Cramps
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dark & Tarry Stools
- ☐ Hernia
- ☐ Vomiting
- ☐ Gallbladder Problems

Genitourinary

- ☐ Blood in Urine
- ☐ Decreased Urine Flow
- ☐ Decreased Urine Frequency
- ☐ Increased Urine Frequency
- ☐ Painful Urination
- ☐ Flank Pain
- ☐ Kidney Stones
- ☐ Kidney Disorders
- ☐ Loss of Bladder Control
- ☐ Prostate Problems
- ☐ Recurrent UTIs

Neurological

- ☐ Carpal Tunnel Syndrome
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Instability When Walking
- ☐ Tremors
- ☐ Seizures

Psychiatric

- ☐ Memory Problems
- ☐ Depressed Mood
- ☐ Feeling Anxious
- ☐ Stressed
- ☐ Mood Swings
- ☐ Suicidal Thoughts
- ☐ Suicidal Planning

Musculoskeletal

- ☐ Joint Pain
- ☐ Joint Clicking
- ☐ Joint Swelling
- ☐ Arthritis

Women

- ☐ Birth Control Pills
- ☐ Irregular Cycle
- ☐ Regular Self-Breast Exams
- ☐ Currently Pregnant
- ☐ Currently Trying
- ☐ Recent Birth (within the last year)
- ☐ Yeast Infection

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Physical Trauma History

Have you had any significant falls, surgeries, accidents, or injuries as an adult? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain and include dates: _____

_____

_____

Have you ever been involved in a Motor Vehicle Accident? ☐ Yes ☐ No

If yes, please explain and include dates: _____

_____

_____

Current Medications

Please list all the medications, supplements, vitamins, and/or herbs you are currently taking:

Medication Name	Medication Dose/Frequency	Reason for Taking

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Social History

How old is your mattress? _____ **How many pillows do you sleep with?** _____

How do you normally sleep? ☐ Back ☐ Stomach ☐ Side

Do you wake up feeling: ☐ Rested ☐ Tired ☐ Stiff

How many hours a day do you typically spend sitting? _____

How frequently do you exercise? ☐ Never ☐ 1-2x/week ☐ 3-5x/week ☐ Daily

What kind of exercise do you do? ☐ Walk/Jog ☐ Weights ☐ Swim ☐ Aerobics ☐ Yoga ☐ Calisthenics ☐ CrossFit ☐ Sports