New Patient Intake Form

Patient Data

Date: ________________
Title: _____ First Name _________________ Middle Initial ____ Last Name __________________
Address ______________________ City _______________ State _____ Zip Code ____________
Home Phone (_____) ________-___________ Work Phone (_____) _________-____________
Cell Phone (_____) ________-___________ Email ___________________________________
Date of Birth ______/______/_______ Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Other
Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____
Professional Title _________________________

Employer Data

Employer Name ____
Address ______________________ City _______________ State _____ Zip Code ____________

Emergency Contact

Contact Name ____________________________ Relationship to Patient ___________________
Home Phone (_____) ________-___________ Cell Phone (_____) _________-____________
Work Phone (_____) ________-___________

How did you hear about our office?

How did you hear about our office? ____

Payment / Insurance Information

Who is responsible for your bill?
☐ Self ☐ Spouse
☐ Health Insurance (including Medicare)
Health Insurance Carrier: _____________ Policy/ID # ____________ Group # ____________
Policy Holder's Name: ________________________________
Policy Holder's Date of Birth ____ / ____ / _____ Primary Care Physician ___________
☐ Auto Insurance
☐ Other ___________________________________

HIPAA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name ____

Patient's Signature ____

Date___________________

Consent to Treat a Minor:

Minor's Name: ______________________________

Guardian / Spouse's Signature Authorizing Care ________________________________

Date___________________

Medical History

Surgeries & Dates:

____
____
____
____

Allergies:

____
____
____
____

All Current Medications:

____
____
____
____
____
____
____
____
____
____

Social History (Check all that apply):

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐>1 pack/day	☐never
Wear Seat Belts:	☐occasional	☐always	☐ never

Other _________________

Family History (Check all that apply):

Arthritis:	☐Parent	☐Sibling
Cancer:	☐Parent	☐Sibling
Diabetes:	☐Parent	☐Sibling
Heart Disease	☐Parent	☐Sibling
Hypertension	☐Parent	☐Sibling
Stroke	☐Parent	☐Sibling
Thyroid	☐Parent	☐Sibling

Other _________________

Patient Name_______________________________ Date____________________

Occupational Activities: (Check one that best describes your job description)

☐Administration	☐Business Owner	☐Clerical/Secretary	☐Computer User
☐Heavy Equipment operator	☐Daycare/Childcare	☐Construction	☐Health Care
☐Food Service Industry	☐Medium Manual Labor	☐Manufacturing	☐Home Services
☐Heavy Manual Labor	☐Light Manual Labor	☐Executive/Legal	☐ Housekeeper
☐Other _________________			

Are you pregnant? ☐Yes ☐No ☐N/A

Review Of Systems

Check box if you have had trouble with any of the following, circle NO if none.

Cardiovascular	Past	Present	No
Poor Circulation	☐	☐	
Hypertension	☐	☐	
Aortic Aneurism	☐	☐	
Heart Disease	☐	☐	
Heart Attack	☐	☐	
Chest Pain	☐	☐	
High Cholesterol	☐	☐	
Pace Maker	☐	☐	
Jaw Pain	☐	☐	
Irregular Heartbeat	☐	☐	
Swelling of legs	☐	☐	

Genitourinary	Past	Present	No
Kidney Disease	☐	☐	
Burning Urination	☐	☐	
Frequent Urination	☐	☐	
Blood in Urine	☐	☐	
Kidney Stones	☐	☐	
Lower Side Pain	☐	☐	

Neurologic	Past	Present	No
Stroke	☐	☐	
Seizures	☐	☐	
Head Injury	☐	☐	
Brain Aneurysm	☐	☐	
Numbness	☐	☐	
Severe Headaches	☐	☐	
Pinched Nerves	☐	☐	
Parkinson's	☐	☐	
Carpal Tunnel	☐	☐	
Vertigo	☐	☐	

Constitutional	Past	Present	No
Weight Loss/Gain	☐	☐	
Low Energy Level	☐	☐	
Difficulty Sleeping	☐	☐	

Respiratory	Past	Present	No
Asthma	☐	☐	
Tuberculosis	☐	☐	
Short Breath	☐	☐	
Emphysema	☐	☐	
Cold/Flu	☐	☐	
Cough	☐	☐	
Wheezing	☐	☐	

Eyes	Past	Present	No
Glaucoma	☐	☐	
Double Vision	☐	☐	
Blurred Vision	☐	☐	

Psychiatric	Past	Present	No
Depression	☐	☐	
Anxiety	☐	☐	
Stress	☐	☐	

Endocrine	Past	Present	No
Thyroid	☐	☐	
Diabetes	☐	☐	
Hair Loss	☐	☐	
Menopausal	☐	☐	
Menstrual	☐	☐	

Hematologic	Past	Present	No
Hepatitis	☐	☐	
Blood Clots	☐	☐	
Cancer	☐	☐	
Bruising	☐	☐	
Bleeding	☐	☐	
Fever, Chills	☐	☐	
Sweating	☐	☐	

Skin	Past	Present	No
Skin disorder	☐	☐	

Allergic/Immunologic	Past	Present	No
Hives	☐	☐	
Immune Disorder	☐	☐	
HIV/AIDS	☐	☐	
Allergy Shots	☐	☐	
Cortisone Use	☐	☐	

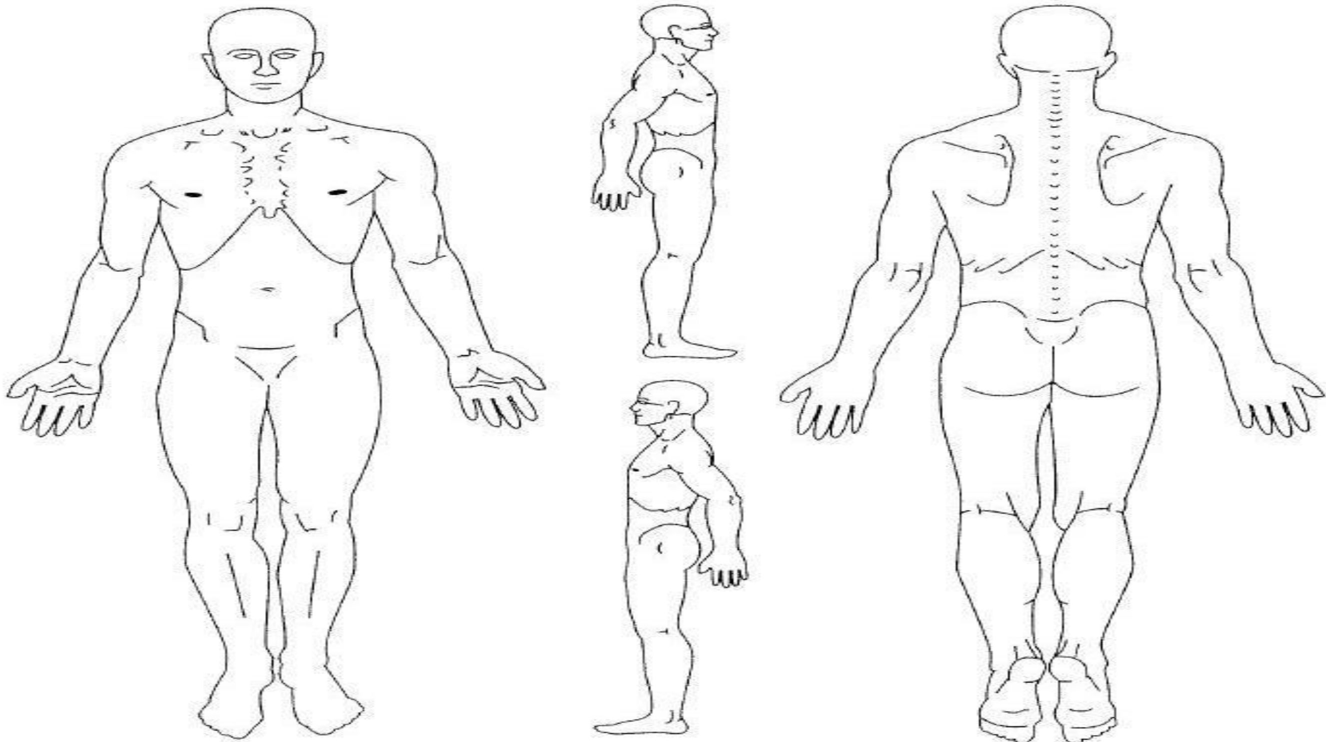
Ear, Nose & Throat	Past	Present	No
Difficulty Swallowing	☐	☐	
Dizziness	☐	☐	
Hearing Loss	☐	☐	
Sore Throat	☐	☐	
Nosebleeds	☐	☐	
Bleeding Gums	☐	☐	
Sinus Infections	☐	☐	

Gastrointestinal	Past	Present	No
Gall Bladder Problems	☐	☐	
Bowel Problems	☐	☐	
Constipation	☐	☐	
Liver Problems	☐	☐	
Ulcers	☐	☐	
Diarrhea	☐	☐	
Nausea/Vomiting	☐	☐	
Bloody Stools	☐	☐	
Poor Appetite	☐	☐	

Musculoskeletal	Past	Present	No
Gout	☐	☐	
Arthritis	☐	☐	
Joint Stiffness	☐	☐	
Muscle Weakness	☐	☐	
Osteoporosis	☐	☐	
Broken Bones	☐	☐	
Joints Replaced	☐	☐	

Current Symptoms____

Indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1:
____
____
____

When did your symptoms begin? Month_____________ Day___________Year _____________

Are your symptoms a result of: ☐Motor Vehicle Accident ☐Work related Accident ☐Other_____

How did your symptoms begin?
____
____

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?
Character: ☐Dull ache ☐Sharp ☐Stabbing ☐Burning ☐Throbbing ☐Stiffness ☐Other:________

What would you rate your pain from 1-10, with 10 being the worst? 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Patient Name______________________________ Date___________________

Effects on Employment, Daily Activities, and Recreation

Condition's Effect On Job Performance*:*

☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability)
☐ **Mod/Sev (**limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Activity				
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

Activity				
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Doctor's Signature ____ Date ______________