BOYKIN
CHIROPRACTIC OFFICE, PC

Phone #: 719-578-8820
2575 Montebello West – Colorado Springs, Colorado 80918

New Patient Intake Form

Patient Biography:

CT #:_____ (For Office to Complete*)

First Name: _____ Last Name: _____

Street Address: _____

City: _____State: _____Zip: _____

Mobile Phone: _____ Email Address: _____

Date of Birth: _____Gender: _____Sex at Birth: (Male / Female)

Height: _____ Weight: _____lbs.

Marital Status: _____ Children: □ Yes / □ No, *If you have children, how many*: _____

Spouse's Name: _____ (N/A)

Your Occupation: _____ Employer: _____

Employer's Address: _____

Are you a Student: □ Yes □ No, *What type of Student?* (High School / College / Post-Graduate)

For Students: Name of Institution: _____

State where the Institution resides in: _____

Town where the Institution resides in: _____

The reason we ask this information for students is so we can plan your care around your schedule and so that we can refer you to another chiropractor in the area of your school if you decide you want to continue seeing a chiropractor during school.

Emergency Contact Information:

Name: _____Phone Number:_____

Relation to you: _____

How Did You Hear About Us?

_____

Were you referred to our office? □ Yes / □ No

If yes, then who referred you? _____

Continued on the Next Page:

Reason for Visit:

If you have a current complaint, then the next section of this form is particularly important for our evaluation. Please fill it out to the best of your ability and answer honestly. If you think something is not relative to your condition you may leave it blank; however, remember that the body is one functional unit and the more we know about you the better we can understand the nature of your health and the nature of your complaint. Sometimes there are related symptoms that practitioners know about, but patients may not think are related to their case and can mean the difference in proper diagnosis and treatment.

Please Indicate the Location(s) of your Complaint/Symptoms on the Body Diagrams and provide a brief description below.

_____

_____

_____

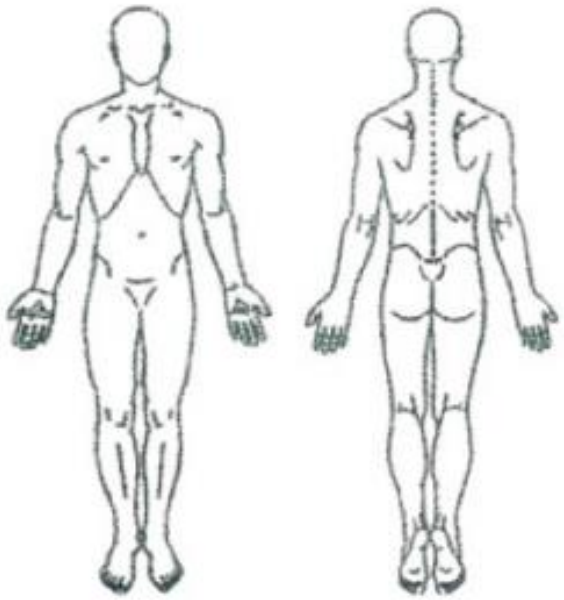
_____

_____

_____

_____

_____



I. **What is your Current Complaint or Condition?** _____

II. **When did this start?** _____

III. **What makes this condition better?** _____

IV. **What makes this condition worse?** _____

V. **What does the complaint feel like?** _____

VI. **On a scale of 0 to 10, with 10 being the worst pain imaginable and 0 being no pain, how do you rate your level of discomfort? (*please mark in a box below*)**

0										10

I. **Is the complaint / pain:** □ Constant / □ Intermittent / □ Occasional

□ **Other (*please explain):*** _____

II. **Has this complaint □ worsened, □ remained the same, or □ improved since you first noticed it?**

_____

III. **Is the nature of the complaint local to one area or does it travel or radiate to any other area of the body?**

_____

a. *If you answered "Yes, the pain radiates" above, then please describe where the pain travels to here:* _____

IV. **When does this complaint bother you the most?**

□ Morning / □ Noon / □ Evening / □ Night

a. Are there any other times the pain/complaint bothers you? _____

_____

V. **Have you ever experienced this complaint before?** □ Yes / □ No

a. If you answered "Yes." above, then please tell us when you last experienced this complaint:

_____

b. Was the previous complaint resolved?

_____

c. What worked to resolve the complaint for you before?

_____

VI. Does this complaint impact your daily life? If yes, then state how:

_____

_____

VII. Have you been able to work?

_____

a. Please state the nature of how the complaint has impacted your work:

_____

VIII. Have you seen any other providers for this complaint? □ Yes / □ No

a. If you answered "Yes." above, then please list the provider here:

_____

IX. Have you had any other symptoms we should be aware of that may be related to your complaint?

_____

a. **Examples:** *Fever, Chills, Tingling, Numbness, Weakness, Headaches, Scapular Pain, Changes in Bladder or Bowel Habits, Changes to Eyesight or Hearing, etc.*

X. Are you on any prescription medications? □ Yes / □ No

a. **Please List ALL Medications you are on:**

_____

_____

_____

_____

_____

b. *Over the Counter Medications and Birth Control are considered a medication and should be listed above**

XI. Have you had any previous Hospitalizations? □ Yes / □ No

a. **If Yes, then please describe what the nature of the hospitalization(s):**

_____

_____

XII. Have you had any previous Surgeries? □ Yes / □ No

a. **If Yes, then please describe what the nature of the operation was and if the operation was an In-Patient Procedure or Outpatient Procedure:**

_____

_____

XIII. Do you have any other diagnosed conditions we should be aware of? □ Yes / □ No

a. **If yes, then please list them:**

_____

_____

b. **Examples:** *Heart Disease, Diabetes, Cancer, Stroke, Lyme Disease, Multiple Sclerosis, etc.*

Social Questionnaire

This is a key section for all patients, please be as honest as possible so we can get a better overview of your health.

Alcohol, Caffeine, Tobacco, and Drug Use:

I. **Do you drink alcohol?** □ Yes / □ No
   a. **How many drinks per week:** _____ drinks.

II. **Do you consume caffeine?** □ Yes / □ No
   a. **How much per week:** _____cups.

III. **Do you use tobacco products?** □ Yes / □ No
   a. **If yes, then how many packs per week do you smoke?** _____ packs
   b. **Are you a previous smoker?** □ Yes / □ No
   c. **If yes, then how many packs per week did you smoke?** _____ packs **and for how many years did you smoke?** _____ years

IV. **Do you use recreational drugs?** □ Yes / □ No

Exercise Habits:

I. **Do you currently exercise?** □ Yes / □ No

II. **How often do you exercise each week?** (1x / 2x / 3x / 4x/ 5x/ 6^{+}x per week)

III. **Can you exercise with your current condition?** □ Yes / □ No

IV. **What type of exercise do you do?**

_____

V. **Do you currently participate in any sports?** □ Yes / □ No
   a. Please List <u>ALL</u> Sports you currently participate in:

   _____

   b. If you previously played sports or had sports injuries, please list them:

   _____

Nutritional Assessment:

I. **How many glasses of water do you drink per day? (Assume 8 oz. Glass): _____glasses**

II. **Are you currently participating in any specific type of diet?** □ Yes / □ No
   What diet/lifestyle are you participating in?

   _____

   a. If there is anything specific we should know about your diet please state it:

   _____

      i. Examples: *Vegan, Vegetarian, Gluten-free, etc.*

III. **Do you take any daily vitamin supplements?** □ Yes / □ No
   a. Please state what product you are taking *(If you know the name)*:

   _____

   b. Do you take any other supplements? □ Yes / □ No
      i. Please list them:

      _____

      _____

IV. **How many meals do you typically eat per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

V. **How many servings of vegetables do you typically get per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

VI. **How many servings of fruits do you typically get per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

VII. **How many servings of meat do you typically get per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

Other:

This section is where you get to tell us about you. Anything that you would like to share with us that has not already been covered on this intake form you can share here. Some examples for this area could be performance goals, dietary concerns, health questions, or other concerns you may have or things you think we should know that could benefit your care. Please share that information below:

_____

_____

_____

_____

_____

_____

_____

Informed Consent:

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

X _____

Patient's First and Last Name

Today's Date: _____/_____/_____