



For Office Use Only
Date: _____
Acct #: _____

Patient Intake Form

Name: _____

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 immediately after the injury: Choose the severity level associated with each symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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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: _____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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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		EXERCISE		FAMILY HISTORY			
<input type="checkbox"/> Smoking	Packs/day: _____	<input type="checkbox"/> None		Diabetes	Cancer	Back Pain	Other
<input type="checkbox"/> Drinking	Alcohol: (Cups/day): _____	<input type="checkbox"/> Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Coffee	Cups/Day: _____	<input type="checkbox"/> Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Soft Drink	Bottles or Cans/Day: _____	Type: _____	Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Water	Cups/Day: _____	_____	Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? Yes No
If yes, which ones?: _____

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

Do you have allergies? Yes No If yes, please explain: _____

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 X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS		GASTRO-INTESTINAL		EYE/EAR		NOSE/THROAT		RESPIRATORY	
<input type="checkbox"/> Allergy(What) _____		<input type="checkbox"/> Belching or Gas		<input type="checkbox"/> Asthma		<input type="checkbox"/> Chest Pain			
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Colon Trouble		<input type="checkbox"/> Deafness		<input type="checkbox"/> Chronic Cough			
<input type="checkbox"/> Chills (Constant)		<input type="checkbox"/> Constipation		<input type="checkbox"/> Earache		<input type="checkbox"/> Difficulty Breathing			
<input type="checkbox"/> Convulsions		<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Ear Discharge		<input type="checkbox"/> Spitting Blood			
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Gall Bladder Trouble		<input type="checkbox"/> Ear Noises		<input type="checkbox"/> Spitting Phlegm			
<input type="checkbox"/> Fainting		<input type="checkbox"/> Hemorrhoids (piles)		<input type="checkbox"/> Thyroid Problems					
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Jaundice		<input type="checkbox"/> Frequent Colds		GENITO-URINARY			
<input type="checkbox"/> Headache		<input type="checkbox"/> Liver Trouble		<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Bed Wetting			
		<input type="checkbox"/> Nausea		<input type="checkbox"/> Nasal Obstruction		<input type="checkbox"/> Blood in Urine			

<p>GENERAL SYMPTOMS</p> <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Night Sweats <input type="checkbox"/> Numbness or Pain in arms/legs/hands <input type="checkbox"/> Wheezing	<p>GASTRO-INTESTINAL</p> <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Heart Burn <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Irritable Bowel	<p>EYE/EAR</p> <p>NOSE/THROAT</p> <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Pain in Eyes <input type="checkbox"/> Poor Vision <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Sinusitis <input type="checkbox"/> Sore Throats <input type="checkbox"/> Tonsillitis	<p>GENITO-URINARY</p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Inability to Control Urine <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Prostate Trouble
<p>MUSCLES & JOINTS</p> <input type="checkbox"/> Backache <input type="checkbox"/> Foot Trouble <input type="checkbox"/> Hernia <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Painful Tail Bone <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Tremors <input type="checkbox"/> Twitching	<p>CARDIO-VASCULAR</p> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart <input type="checkbox"/> Slow Heart <input type="checkbox"/> Strokes <input type="checkbox"/> Swelling Ankles <input type="checkbox"/> Varicose Veins	<p>SKIN OR ALLERGIES</p> <input type="checkbox"/> Bruising Easily <input type="checkbox"/> Dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Hives or Allergy <input type="checkbox"/> Itching <input type="checkbox"/> Sensitive Skin <input type="checkbox"/> Skin Eruptions	<p>FOR FEMALES ONLY</p> <input type="checkbox"/> Cramps <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Painful Periods <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Pregnant Now? _____ Last Pap Date _____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles
<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> 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:** _____