



New Patient Intake Form

Name _____ Date _____

Address _____ Employer _____

City, State, Zip: _____ Type of work _____

Email _____ If retired, what was your occupation? _____

Phone (home) _____ (cell) _____ (work) _____

Date of Birth _____ Age _____ Travel time to this office _____

Gender: F M Other • Enrolled in Medicare _____

Height: _____ ft _____ in Current weight: _____ Lowest adult weight _____ Highest _____ Desired _____

Marital Status: S M W D Partnered

Name of Spouse/Partner _____ Medical Doctor _____

Spouse's Occupation _____ Referred to our office by _____

Name(s) and Age(s) of Children _____

Name of person responsible for payment of professional service _____



CURRENT HEALTH REPORT

Please describe the principal health problems for which you would like to come to this office. Include approximate date of onset.

* Type: P=Pain; A=Ache; ST=Stiffness; N=Numbness; T=Tingling; S=Soreness; O=Other

** Pain: For each complaint, rate the level of current pain on a scale of 1-10. 1=no pain; 10=severe pain

| <u>Principal Health Problems</u> | <u>Type</u> * |
|----------------------------------|---------------|
| <u>Pain</u> ** | |
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

What are your long-term goals in coming to this office? _____

How long has it been since you have felt well? _____

Are your present complaints due to an injury? no yes auto accident other

Is your condition getting progressively worse? no yes • Pain is: constant comes and goes

Is your condition interfering with your: work sleep daily routine other _____

Have you lost any days of work? no yes Dates _____

What activities aggravate your condition? _____

What makes it feel better? _____

Have you had this or a similar condition before? no yes If yes, explain _____

Has anyone in your family had a similar condition before? no yes If yes, who? _____

Past chiropractic treatment no yes When? _____ Explain _____



Have you seen any other physicians for this condition? _____

List diagnoses and describe treatment _____

Do you wear: Heel lifts Orthotics Dental night guard

Have you been treated for any other health condition by a physician in the last year? no yes If yes, explain: _____

Are you currently taking prescription medication? no yes If yes, what? _____

Have you ever been on frequent or prolonged antibiotic therapy (such as erythromycin, penicillin, tetracycline, etc.)? _____

Current non-prescription pain relievers (Aleve, Tylenol, Aspirin, Ibuprofen, etc.). How many per day? _____

Other current non-prescription medications (laxatives, antihistamines, decongestants, stimulants, etc.): _____

Are you currently taking any vitamins or supplements? no yes If yes, what? _____

Allergies or sensitivities to drugs, foods, pollens, chemicals, animals, etc. _____

HABITS OF DAILY LIVING

Exercise: None Moderate Heavy • <1 per week 1-3 times per week Daily

Hours/ week _____

Work Activity (check all that apply): Sitting Standing Walking Light Labor Heavy Labor

Stress level: High Moderate Low • Do you do any stress reduction or relaxation activities such as meditation, yoga, prayer, etc.? _____



Are you currently on psychotropic medication or receiving psychological counseling? Please describe:

What are your favorite hobbies or other life interests? _____

Sleep habits: Hours per night _____ Restless or restless? _____ Do you dream? _____

What time do you go to bed? _____ Do you sleep through the night? _____

Alcohol consumption: Drinks per week _____ Have you ever felt the need to cut down? _____

Tobacco consumption: Do you smoke? _____ How much per day? _____ How long?

Did you ever smoke? _____ How much for how long? _____ When did you stop? _____

Non-medical drug use: Type and frequency _____

Chemical exposure: Do you regularly use: Cosmetics Perfumes Aftershaves Scented soaps/products

Do you have amalgam dental fillings? yes no • Any prolonged exposure to paints or solvents? yes no

Other known notable chemical exposures: _____

Diet: Do you eat regular meals? yes no • Do you sit down for meals? yes no • Do you normally eat or drink between meals? yes no What? _____

How often does your diet consist mainly of some or all of the following: salads, whole grains, eggs, fresh fruits and vegetables, lean meats, beans or legumes? rarely sometimes often almost always

Are you a vegetarian? yes no • Do you eat processed foods with artificial colorings, flavorings or preservatives (e.g. bologna, sausage, cheese spreads, baked goods)? rarely sometimes often



Do you eat “fast food”? rarely sometimes often

What and how often? _____

Do you add sugar to coffee, tea, cereals, other foods? yes no • Do you use artificial sweeteners? yes no

How many servings of:

| | | | |
|----------------------------|-------------------|---------------------|-------------------------|
| ___ Fruit/day | ___ Fish/week | ___ Water/day | ___ Tea/day |
| ___ Vegetables/day | ___ Fowl/week | ___ Soft Drinks/day | ___ Chocolate/Cocoa/day |
| ___ Sweets/day | ___ Red meat/week | ___ Coffee/day | ___ Cow dairy/day |
| ___ Wheat (bread etc.)/day | | | (cheese, milk, yogurt) |

GENERAL HEALTH HISTORY

List any major accidents, serious falls or injuries (with dates) _____

Broken bones, cranial injuries _____

List surgeries/hospitalizations (with dates) _____

List X-rays or special imaging taken in the last 10 years and their dates _____



Please check all that you have or have had:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Grave's Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hashimoto's Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis/Bowel Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Autism | | |

Have you ever lived or traveled outside of the United States? yes no • Had travelers diarrhea? yes no

Have you ever been tested for intestinal parasites? yes no • Been treated for intestinal parasites? yes no

If yes, please describe when, and what parasite(s) _____



CHILDHOOD HISTORY

Childhood illnesses:

- | | | | |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Recurrent Colds | <input type="checkbox"/> Colic | <input type="checkbox"/> Mumps | <input type="checkbox"/> Frequent Antibiotics |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Persistent Diaper Rash | <input type="checkbox"/> Rubella | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Chicken Pox | |

Was your home life (check all that apply):

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Loving | <input type="checkbox"/> Fun | <input type="checkbox"/> Loud | <input type="checkbox"/> Alcoholic |
| <input type="checkbox"/> Supportive | <input type="checkbox"/> Educational | <input type="checkbox"/> Argumentative | <input type="checkbox"/> Physically Abusive |
| <input type="checkbox"/> Peaceful | <input type="checkbox"/> Stressful | <input type="checkbox"/> Single Parent | <input type="checkbox"/> Verbally Abusive |
| <input type="checkbox"/> Filled with positive | <input type="checkbox"/> Financially Stressed | <input type="checkbox"/> Lonely or Neglectful | <input type="checkbox"/> Sexually Abusive |

extended family

FAMILY HISTORY

| | Diabetes | Heart Disease/High Blood Pressure | Cancer | Musculoskeletal | Other Problems |
|----------------|--------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------|
| Grandparent(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sibling(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Age of biological parents _____ If deceased, age and cause: _____



SYSTEMS REVIEW

Please write: C = Constantly in the present O = Occasionally in the present P = In the past

| GENERAL | MUSCLES & JOINTS | CARDIOVASCULAR | RESPIRATORY |
|---|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hernia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg cramps when walking | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Spitting blood |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Musculoskeletal birth defects | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Spitting phlegm |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Rapid heart | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pain, numbness or tingling in: | <input type="checkbox"/> Slow heart | |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Swelling ankles | GENITO-URINARY |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Arms | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Elbows | EYE/EAR/NOSE/THROAT | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Thirst Abnormal | <input type="checkbox"/> Hands | <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Hips | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Legs | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Kidney infection |
| GASTRO-INTESTINAL | <input type="checkbox"/> Knees | <input type="checkbox"/> Farsightedness | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Belching or gas | <input type="checkbox"/> Feet | <input type="checkbox"/> Nearsightedness | <input type="checkbox"/> Night urination |
| <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Painful tailbone | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Earache | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Ear discharge | FOR WOMEN ONLY |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Cramps or backache |
| <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Excessive flow |
| <input type="checkbox"/> Hemorrhoids (piles) | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Hearing sensitivity | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Intestinal parasites | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Nasal obstruction | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Jaundice | SKIN | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Boils | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Pain over stomach | <input type="checkbox"/> Dryness | <input type="checkbox"/> Hay fever | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Poor digestion | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pregnant at this time? |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hives or allergies | <input type="checkbox"/> Sore throats | Last Pap _____ |
| THYROID | <input type="checkbox"/> Itching | <input type="checkbox"/> Enlarged glands | Menstrual cycle: _____ days |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Sensitive skin | <input type="checkbox"/> Enlarged thyroid | Date of last period: _____ |
| <input type="checkbox"/> Underactive | <input type="checkbox"/> Skin eruptions | <input type="checkbox"/> Dental decay | |
| <input type="checkbox"/> Enlarged | | <input type="checkbox"/> Grinding teeth | |