

Patient Intake Form

Date _____

First Name _____

Last Name _____

DOB _____

Sex Male Female

SSN _____

Address _____

City _____

State _____

Zip Code _____

Phone 1 _____
 Home Mobile Work Other

Phone 2 _____
 Home Mobile Work Other

Fax _____

Email _____

Employer _____

Employer Phone _____

Occupation _____

Job Status
 Not Employed Employed
 Part-Time Student Retired
 Full-Time Student

Marital Status
 Single Married Other

Receive Appointment Reminders
 Declined Voice Text Email

Height _____' _____" Weight _____ lbs

Reason For Visit: New Patient Adjustment Physical Consultation X-Rays Therapy Injury
 Report of Findings Auto Accident Re-Examination Other _____

Referred By: Provider Friend Family Other _____
Referred By Name _____

How Heard of Us: Walk in Referral Phone Book Website
 Advertisement Other _____

Demographics

Race: White Black or African American American Indian or Alaska Native Asian
 Native Hawaiian or Other Specific Islander Other _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown Other _____

Dominance: Right Left Ambidextrous

Insurance Information

Primary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured Self Spouse Child Other _____

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

\$/Year _____ Visits/Year _____ Therapy Visits/Year _____

PCP Referral Required Yes No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Secondary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured Self Spouse Child Other

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

\$/Year _____ Visits/Year _____ Therapy Visits/Year _____

PCP Referral Required Yes No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Emergency Contact Information

First Name _____

Relationship _____

Last Name _____

Phone 1 _____

Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

- AIDS/HIV Chronic Fatigue Heart Disease Miscarriage Seizures
- Anemia Depression Hepatitis Multiple Sclerosis Stroke
- Arthritis Diabetes Hernia Osteoporosis Suicide Attempt
- Asthma Emphysema Herniated Disc Pacemaker Thyroid Problems
- Bleeding Disorders Epilepsy High Blood Pressure Parkinson's Disease Tuberculosis
- Breast Lump Fibromyalgia High Cholesterol Pinched Nerve Tumors/Growths
- Bronchitis Fractures Immune Deficiency Prostate Problems Ulcers
- Cancer Gallstones Kidney Disease Prosthesis Vaginal Infections
- Chemical Dependency Glaucoma Liver Disease Psychiatric Disorder Venereal Disease
- Chicken Pox Gout Migraine Headaches Rheumatoid Arthritis Whooping Cough
- Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries:

Traumas:

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Does the pain travel anywhere else? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? _____

Frequency: _____ times per Day Week Month Year

Duration: Lasting _____ Minutes Hours

Onset: Have had symptoms over the past _____ Days Weeks Months Years

Intensity: Minimal Slight Moderate Severe

Is your condition: Same Better Worse

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10
0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: aching burning cramping deep dull numb radiating sharp
 shooting sore stabbing stiff swelling tight tingling throbbing

Aggravating Factors: What makes the problem worse? nothing most movements bending carrying things
 coughing driving eating exercise going down stairs going from lying to sitting
 going from lying to standing going from sitting to standing heat housework ice jogging lifting
 lying down massage pulling pushing running sitting sleeping sneezing squatting
 standing standing for a long period of time stress stretching taking a deep breath turning
 twisting walking working

Relieving Factors: What makes the problem better? nothing anti-inflammatories bracing chiropractic care
 elevation exercise heat ice massage movement pain killers rest stretching
 walking wraps

What daily activities are affected due to the problem? bathing caring for children cleaning climbing stairs
 cooking doing laundry dressing driving eating exercising going from laying down to sitting
 going from sitting to standing grooming house work laying down lifting oral care sex
 shopping sitting sleeping social/recreational activities standing stretching toileting
 transferring using technology using phone walking watching tv working yard work

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? None Medication Surgery Physical Therapy
 Chiropractic Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: Good Insufficient Erratic

Low (Time of Day) _____ High (Time of Day) _____

Sleep: Trouble falling asleep Trouble staying asleep Restful Other _____

Stress: None Low Moderate Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? Yes No If yes, how much? _____

Daily Habits

Do you smoke? Never smoked Unknown if ever smoked Unknown if currently smokes

Current every day smoker Current some day smoker Former smoker

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: Unknown None 1 to 3 4 to 6 7 to 10 11 to 15 16 to 20 21 to 25 Over 25

Weekly Alcoholic Drinks: Unknown None 1 to 3 4 to 6 7 to 10 11 to 15 16 to 20 21 to 25 Over 25

Do you exercise regularly? no light moderate heavy

Review of Systems

Musculoskeletal: Please check all that apply None

Arm/hand pain back pain Feet/leg pain hip Knee Lower back pain Mid back pain Muscle or joint pain

Neck pain Redness of joints Shoulder(s) pain Stiffness Swelling of joints Upper back pain

Cardiovascular/Respiratory: Please check all that apply None

Chest pain, pressure or discomfort Cold hands/feet Coughing up blood (hemoptysis) Coughing up phlegm Persistent Coughing

Difficulty breathing Dizziness/lightheaded Fainting Irregular heartbeat Palpitations

Shortness of breath Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

Swelling (edema) Tightness in chest Wheezing Other _____

Head/Neck: Please check all that apply None

Dizziness Facial pain Grinding Teeth Headache Head injury Hoarseness Jaw Clicks Lumps

Migraines Pain Sore throat Stiffness Swollen Glands Tooth problems Trouble swallowing

Other _____

Eyes: Please check all that apply None

Blurred Vision Burning Cataracts Double vision Dryness Flashing lights Glasses/Contacts Glaucoma

Itching Pain Redness Specks Vision Problems Other _____

Ears: Please check all that apply None

Buzzing in ears Decreased hearing Drainage Earache Ear infections Poor balance Poor hearing

Ringing in ears (tinnitus) Other _____

Nose: Please check all that apply None

- Allergies Blocked Sinuses Discharge Excessive mucus Hay fever Itching Nose bleeds
 Sinus pressure/pain Stuffiness/blockage Other _____

Throat/Mouth: Please check all that apply None

- Bleeding Blue lips Braces Dentures Difficulty swallowing Dry mouth Hoarseness
 Mouth pain Non healing sores Redness Sore throat Sores on lips or tongue Swelling
 Thrush Tooth pain Other _____

Urinary: Please check all that apply None

- Blood in urine (hematuria) Burning or pain Difficulty urinating Frequent urinary tract infections
 Frequent urination Incontinence Kidney infections Kidney stones Unable to hold urine (incontinence)
 Up at night to urinate Urgency Water retention Other _____

Gastrointestinal: Please check all that apply None

- Change in appetite Change in bowel habits Constipation Diarrhea Heartburn Nausea
 Rectal bleeding Swallowing difficulties Yellow eyes or skin (jaundice) Other _____

Endocrine: Please check all that apply None

- Change in appetite Cold intolerance Constipation Diarrhea Dry skin Excessive thirst
 Frequent urination Heat intolerance Sweating

Vascular/Hematologic: Please check all that apply None

- Calf pain with walking (claudication) Cold hands and feet Ease of bleeding Ease of bruising Leg cramping

Neurologic: Please check all that apply None

- Dizziness Easily angered/irritated Fainting Frequent crying Memory confusion Nervousness Neuralgia
 Numbness Poor concentration Seizures Suicidal thoughts Tingling Tremors Weakness
 Worry/anxiety Other _____

Psychiatric: Please check all that apply None

- Anxiety Depression Memory loss Nervousness Stress Other _____

Female:

- Are you pregnant? Yes No Date of last period _____ Number of days between periods _____
Age started _____ Age stopped _____
Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____
Number of abortions _____ Number of Cesareans _____ Operations Cervix Uterus Ovaries

Please check all that apply None

- Clotting Dark color Discharge Food cravings Heavy bleeding Hot flashes Infections
 Irregular periods Itching or rash Leg cramps Light bleeding Little/no sex drive Menstrual pain/cramps
 Missed periods Mood swings Painful breasts Pain with sex STD's Vaginal discharge
 Vaginal dryness Vaginal sores Water retention Other _____

Male: Please check all that apply None

- Discharges Erectile dysfunction Hernia Impotence Low sex drive Masses or pain Painful urination
 Pain with sex Painful discharge Prostate problems Sores STD's Other _____

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

Signature of Patient, Parent, Guardian or Personal Representative

Date _____

Print Name of Patient, Parent, Guardian or Personal Representative

Date _____