New Patient Intake Form

Name_____ D.O.B. (D/M/Y) _____Age_____
Address_____ Postal Code_____
Health Care# _____ Gender M / F
Marital Status_____ Name of Spouse_____# children_____
Phone # (H) _____ (W) _____ (C) _____
Occupation_____Employer_____
Height_____ Weight_____ Hobbies_____
How did you hear about our clinic? _____

Chiropractic Information

Have you been to a chiropractor? Y / N Chiropractor's Name_____
What were you treated for_____ X-Rays taken? Y / N
What is bothering you now_____
How long have you had this condition? _____ Is it getting worse/ Y / N
Have you had similar condition in the past? Y / N When? _____
What aggravates this condition? _____
What improves this condition? _____
What aspects of daily life does this condition affect? _____
How do you sleep? on back on side on stomach combination
Is this injury WORK RELATED? Y/N
Did you report it to your employer? Y/N

Medical Information

Medical Doctor_____ Date of last physical _____
Please list any surgical operations: Year of Surgery
_____ _____
_____ _____
_____ _____

Have you ever been in a car accident? Y / N Date_____
Any other accidents, injuries, broken bones etc? Y / N
past year past 5 years over 5 years
Please describe above traumas briefly_____
_____
List any allergies you have_____
Please list **all** vitamins/medications you are on _____
_____
What are these medications for? arthritis muscle relaxants pain killers
other (please describe) _____

Please answer the following questions carefully, as these various conditions can affect the overall course of your chiropractic treatment.

Check any of the following conditions you have **ever** had:
___Appendicitis ___Tuberculosis ___Malaria ___Epilepsy ___Mental Disorder

___Pneumonia ___Anemia ___Pleurisy ___ Polio ___Alcoholism
___Venereal disease ___Rheumatic fever ___Diabetes ___Arthritis ___Psoriasis
___Cancer ___Goiter ___Eczema ___Thyroid(hypo/hyper)

Check any of the following which you have had in the **last 6 months**:

Musculo-skeletal

___Low back pain ___ Mid back pain ___Joint stiffness ___Jaw pain
___Neck pain ___Leg pain ___Arm pain ___Walking Problems

Nervous System

___numbness ___stress ___paralysis ___forgetful ___cold/tingling extremities
___dizziness ___nervous ___fainting ___seizures ___confusion/depression

Gastro-Intestinal

___poor/excessive appetite ___liver problems ___excessive thirst ___diarrhea
___ black/bloody stool ___weight problems ___heartburn ___frequent nausea
___constipation ___abdominal pain ___colitis ___bloating
___gall bladder problems ___vomiting ___irritable bowel syndrome

Genito-Urinary

___bladder troubles ___pain/excessive urination ___discolored urine
Male prostate/sexual dysfunction
Females Are you pregnant? Yes No Not Sure
When was your last period? _____
Any problems with menstruation? _____
Did your last physical include: Pap smear breast exam
Do you do a monthly self breast exam? Yes No

Heart Conditions

___pace maker ___short of breath ___blood pressure problems ___irregular heartbeat
___lung disease ___chest pain(angina)___arterio/atherosclerosis ___ankle swelling
___varicose veins ___stroke

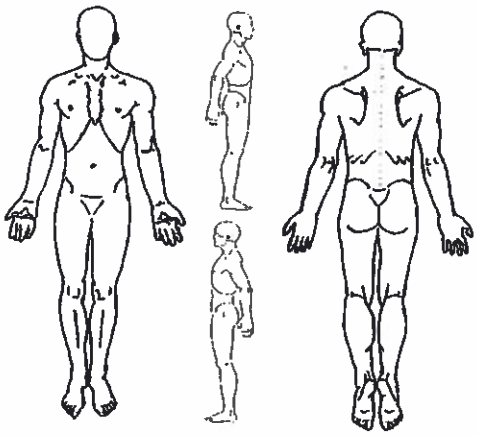
Lifestyle

___fatigue ___loss of sleep ___fever ___headaches ___coffee
___tea ___pop ___tobacco ___alcohol

Other

___vision problems ___dental problems ___ear infections ___hearing problems

Using the appropriate symbols, mark the area of your body where you feel the described sensations. Include all affected areas. (**) Numbness (!!!) Pins & Needles
(XX) Aching (ZZ) Burning (VV) Stabbing



Please mark on the line your **present** pain level:
NO PAIN 0----1----2----3----4----5----6----7----8----9----10 WORST PAIN