New Patient Intake Form

Date: _____

Name: _____ **I prefer to be called:** _____

Home Address: _____

Phone: _____ **Email:** _____

Age: _____ **Height:** _____ **Weight:** _____

Primary Care Doctor: _____

How did you hear about this office? _____

_____

Have you seen a chiropractor before? Yes / No

Any preferences as to how you like to be adjusted? _____

_____

Chief complaint/reason for visit today: _____

_____

_____

_____

_____

How long has this been going on? _____

Any known inciting event: _____

_____

_____

Have you seen anyone for treatment prior to now: Yes / No

Whom/what treatment: _____

_____

_____

_____

Circle any qualities that describe your symptoms:

Numbness / Burning / Stabbing / Aching / Tingling / Tightness / Sharp / Dull / Weak

Grade your pain as of right now: (Please circle one: 0 = no pain; 10 = worst pain imaginable)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Does your pain stay in one place or radiate anywhere? Please explain: _____

_____

_____

Do your symptoms seem to be:

getting worse / not changing / getting better

Does anything make your symptoms <u>better</u>? e.g. time of day, position, activity, etc. _____

_____

_____

Does anything make your symptoms <u>worse</u>? e.g. time of day, position, activity, etc. _____

_____

_____

HEALTH HISTORY

Circle all varieties of health issues <u>you</u> currently have or have had in the past:

Cancer / Diabetes / Infectious Diseases / Heart, Lungs, Circulation / Skin / Digestive System / Psychosocial Health / Skeleton and Joints / Urinary / Nervous System / Headaches / Chronic Immune System Deficiencies / Reproductive System / Thyroid / Eyes, Ears, Nose, Throat

Details/Other: _____

_____

_____

_____

Circle any conditions that your <u>immediate family members</u> currently have or have had in the past:

Cancer / Diabetes / Stroke / Thyroid Issues / Heart Disease / Psychosocial Health

Details/Other: _____

_____

_____

Please list any traumas/injuries/surgeries and their dates: _____

_____

_____

_____

Have you ever experienced a concussion? Yes / No

Have you ever experienced a loss of consciousness? Yes / No

Please list all known allergies: _____

_____

Please list all medications and dietary supplements. Please include dose if known, reason for taking, and prescribing doctor): _____

_____

_____

_____

_____

_____

_____ Please continue on back of page if more space is needed.

Do you have children? Yes / No **If yes, how many:** _____

Females, please list: **Number of pregnancies:** _____ **Number of births:** _____

Have you had preventive health screenings for the following (check all that apply):

□ **Blood pressure within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Breast exam within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Pap smear within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Prostate exam within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Colonoscopy within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Fasting blood glucose within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Cholesterol within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Blood lipids within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Dental within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never

Did the results of any of these screenings cause concern for you or your doctor? Please explain: _____

_____

_____

LIFESTYLE

About how many hours of sleep do you get per night? _____

From what time to what time? _____

Do you feel rested when you wake? Yes / No

Do you have difficulty falling asleep? Yes / No

Do you have difficulty staying asleep? Yes / No

About how many glasses of water do you drink /day? _____

How would you describe your diet overall? _____

_____

Please describe the usual food and drink you consume for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Rate your current perception of stress in your life:
(Please circle one: 0 = no stress; 10 = unmanageable stress)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Do you feel like you have adequate support and skills to manage your current life stressors? Yes / No

What type of work do you do? _____

How do you feel about what you do for work? (Circle one)

Strongly dislike / Dislike / Neutral / Like / Love!

What is the physical nature of your job? (Circle any that apply)

Sitting for long periods / Standing for long periods / Take breaks to move / Repetitive motions

About how many alcoholic drinks do you consume <u>per week</u>? _____

About how many caffeinated drinks do you consume <u>per day</u>? (and what kind?) _____

_____

Do you use tobacco products? Yes, currently / No / Yes, in the past (quit)

What physical activity/activities do you enjoy? _____

_____

_____

On average, how much physical activity have you gotten over the past month? (Circle one)

None Less than 1x/week 1x/ week 2-3x/ week 4 or 4+x/ week

GOALS/RECOMMENDATIONS

What are your treatment goals/expectations? _____

_____

_____

_____

_____

At this point in time, would you like recommendations for:

Nutritional Support / Postural Exercise / Breathing Exercises / Stress Management / Additional Complementary Services (massage, acupuncture, homeopathy, functional neurology, naturopathic medicine, midwifery, yoga, Pilates, etc.)

Other: _____

_____

ODDS AND ENDS

Is there anything else that you feel is important that I should know about you? _____

_____

_____

_____

_____

_____

_____

_____