NEW PATIENT INTAKE

Name: _____ Date: _____
Address: _____ City: _____ Zip _____
Cell #: _____ Carrier:_____
Email Address: _____ Male: ☐ Female:☐
Social Security # _____ Birth Date: _____ Age: _____
Occupation: _____
Employer Name & Address: _____
Single: ☐ Divorced:☐ Widowed: ☐ Other:☐ Married: ☐ Spouse's Name: _____

(*FEMALES ONLY*) Are you Pregnant? Yes ☐ No ☐

Have you seen a Chiropractor before? Yes ☐ No ☐ If yes, when: _____

Whom may we thank for referring you to our office? _____

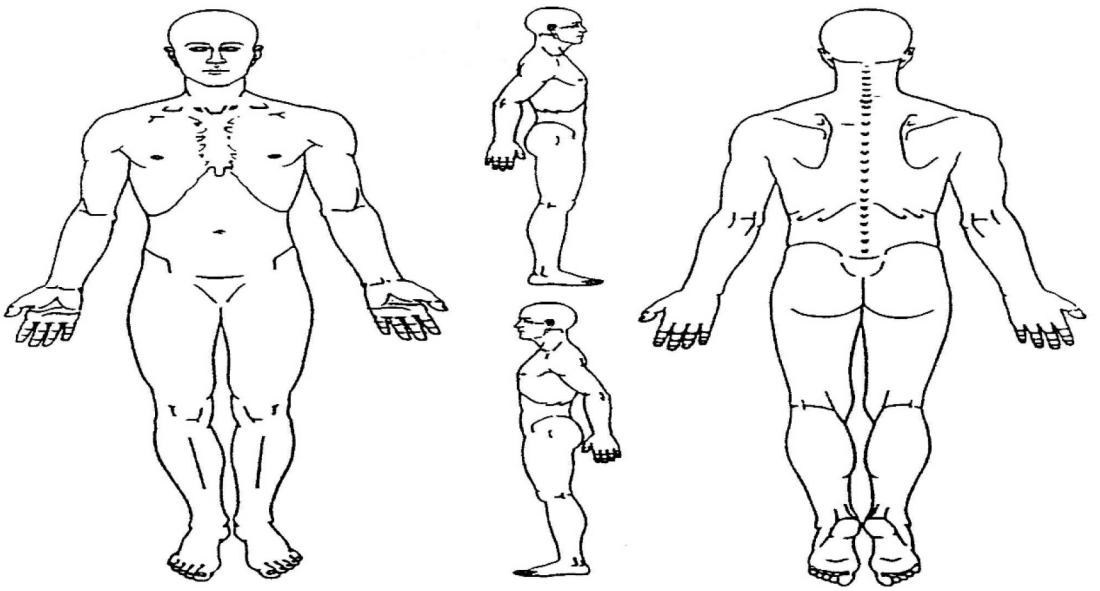
Your Health Summary

PLEASE check all the symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & needles in legs	☐ Fainting	☐ Anxiety
☐ Pins & needles in arm	☐ Loss of smell/taste	☐ Mid back pain	☐ Upset stomach
☐ Dizziness	☐ Buzzing/ringing in ears	☐ Irritability	☐ Tension
☐ Numbness in fingers	☐ Numbness in toes	☐ Cold hands	☐ Shoulder pain
☐ Fatigue	☐ Depression	☐ Fever	☐ Hot flashes
☐ Sleep problems	☐ Sciatica	☐ Problem urinating	☐ Heart burn
☐ Diarrhea	☐ Constipation	☐ Menstrual Irregularity	☐ Ulcers
☐ Low Back Pain	☐ Knee/Ankle pain	☐ Neck pain/stiffness	☐ High blood pressure
☐ Mood swing	☐ Menstrual pain	☐ Loss of balance	☐ High cholesterol

Other Health problems or concerns:_____

Please mark the areas on your body where you feel pain. Include all the affected areas. If the pain radiates draw an arrow to indicate the direction.



On a scale of 0-10, with 0 being completely Able to function and 10 being completely Un-able to function, please circle the number which best describes how your pain affects these six categories of activities.

1. FAMILY / AT-HOME RESPONSIBILITIES SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL- 0 1 2 3 4 5 6 7 8 9 10
2. RECREATION INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES – 0 1 2 3 4 5 6 7 8 9 10
3. SOCIAL ACTIVITIES INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT, AND ATTENDING OTHER SOCIAL FUNCTIONS – 0 1 2 3 4 5 6 7 8 9 10
4. EMPLOYMENT INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS – 0 1 2 3 4 5 6 7 8 9 10
5. SELF -CARE SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED – 0 1 2 3 4 5 6 7 8 9 10
6. LIFE –SUPPORT ACTIVITIES SUCH AS EATING AND SLEEPING – 0 1 2 3 4 5 6 7 8 9 10

List any medications you are taking: _____

Please check to indicate any current medications you are taking (over the counter or prescription):

☐ Aspirin/Tylenol/Advil ☐ Pain Killers ☐ Anti-Depressants ☐ Other:_____

Have you had any surgeries or hospitalizations: Y/N If yes, when?_____

Have you EVER been in a motor vehicle accident: Y/N If yes, when?_____

The statements made on this form are accurate to the best of my recollections and I agree to allow this office to examine me for further evaluation

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____