INTAKE INFORMATION

Date:

CONFIDENTIAL PATIENT INFORMATION

Patient's last name: First: Middle Initial:	Nickname:	Date of Birth:	Sex: ❑M ❑F

Street address:	Work Phone:	Home Phone:	Preferred Phone: ❑Home ❑Work ❑Cell
City:	Cell Phone:	Social Security Number:	
State:	Zip Code:	Email:	Employer:

❑Single ❑Married ❑Divorced ❑Widowed ❑Partner Spouse/Partner Name:

Can we contact you via e-mail? Choose ONE: ❑Yes ❑No | Who referred you to our office:

Preferred Language: ❑English ❑Spanish ❑German ❑French ❑Italian ❑Russian ❑Portuguese ❑Chinese ❑Japanese ❑Korean ❑Vietnamese ❑Decline to Answer ❑Other _____

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Other ❑Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Preferred Communication: ❑Cell Phone ❑Home Phone ❑Work Phone ❑Mail ❑Email ❑In Person

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year _____ Quit Date _____

Current Medications:
1.Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____ Frequency (e.g. once daily) _____Date Started: _____
2. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____ Frequency (e.g. once daily) _____Date Started: _____
3. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____ Frequency (e.g. once daily) _____Date Started: _____
4. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____ Frequency (e.g. once daily) _____Date Started: _____
5. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____ Frequency (e.g. once daily) _____Date Started: _____

Drug Allergies:
1. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
2. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
3. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

List Supplements:

INSURANCE INFORMATION

Primary Insurance:	Insured ID:
Insured Name:	Group Number:
Patient is the ❑Spouse ❑Child ❑Self ❑_____ to the insured.	Ins. Date of Birth:

Insured Address (if different from patient):

Address 2:	City:	State:	Zip Code:
Deductible?	Coinsurance/Copay?		
Secondary Insurance:	Insured ID:		

FAMILY HISTORY

Please indicate which conditions exist or have existed by marking the boxes below.

	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer	❑	❑	❑	❑	❑	❑	❑
Brain Cancer	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑	❑
Gastric Cancer	❑	❑	❑	❑	❑	❑	❑
Kidney Cancer	❑	❑	❑	❑	❑	❑	❑
Leukemia	❑	❑	❑	❑	❑	❑	❑
Liver Cancer	❑	❑	❑	❑	❑	❑	❑
Muscle Cancer	❑	❑	❑	❑	❑	❑	❑
Other Cancer	❑	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑	❑
Pancreatic Cancer	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Rectal Cancer	❑	❑	❑	❑	❑	❑	❑
Skin Cancer	❑	❑	❑	❑	❑	❑	❑
Thyroid Cancer	❑	❑	❑	❑	❑	❑	❑
Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Deep Vein Thrombosis	❑	❑	❑	❑	❑	❑	❑
Pulmonary Embolism	❑	❑	❑	❑	❑	❑	❑
Unknown Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia/Alzheimer's	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Gestational Diabetes	❑	❑	❑	❑	❑	❑	❑
Impaired Fasting Glucose	❑	❑	❑	❑	❑	❑	❑
Insulin Resistance	❑	❑	❑	❑	❑	❑	❑
Maturity onset Diabetes (MODY)	❑	❑	❑	❑	❑	❑	❑
Pre-Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 1 Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 2 Diabetes	❑	❑	❑	❑	❑	❑	❑
Colon Polyp	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑
Familial adenomatous polyposis (FAP)	❑	❑	❑	❑	❑	❑	❑
Gastrointestinal Disorder	❑	❑	❑	❑	❑	❑	❑
Irritable Bowel Syndrome	❑	❑	❑	❑	❑	❑	❑
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	❑
Lynch Syndrome	❑	❑	❑	❑	❑	❑	❑
Angina	❑	❑	❑	❑	❑	❑	❑
Coronary Artery Disease	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Heart Disease	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Cystic Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Chronic Kidney Disease (assoc. Diabetes Type 2)	❑	❑	❑	❑	❑	❑	❑
Congenital Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Kidney Nephrosis	❑	❑	❑	❑	❑	❑	❑
Nephritis	❑	❑	❑	❑	❑	❑	❑
Nephrotic Syndrome	❑	❑	❑	❑	❑	❑	❑
Other Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
COPD	❑	❑	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑	❑	❑

Name_____ **Confidential** **File:** _____ **Date:** _____

	Self	Mother	Father	Sister	Brother	Son	Daughter
Chronic Lower Respiratory Disease	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑
Influenza	❑	❑	❑	❑	❑	❑	❑
Pneumonia	❑	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑	❑	❑
Bipolar Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑	❑	❑
Mental Disorder	❑	❑	❑	❑	❑	❑	❑
OCD	❑	❑	❑	❑	❑	❑	❑
Panic Disorder	❑	❑	❑	❑	❑	❑	❑
Personality Disorder	❑	❑	❑	❑	❑	❑	❑
PTSD	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Social Phobia	❑	❑	❑	❑	❑	❑	❑
Septicemia	❑	❑	❑	❑	❑	❑	❑
Stroke/Brain Attack	❑	❑	❑	❑	❑	❑	❑
Sudden Infant Death Syndrome	❑	❑	❑	❑	❑	❑	❑

PATIENT HISTORY

Who is your Primary Doctor?

Do you see any specialists?

Have you seen a Chiropractor or PT?

Please describe your past accidents:

1.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
2.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
3.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe
_____

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: _____

Please indicate which conditions YOU (the patient) have experienced by marking the boxes below.

AIDS	❑	Allergies	❑	Anemia	❑	Arthritis	❑
Asthma	❑	Back Pain	❑	Bladder Trouble	❑	Bone Fracture	❑
Cancer	❑	Chest Pain	❑	Concussion	❑	Constipation	❑
Convulsions	❑	Depression	❑	Diarrhea	❑	Dislocated Joints	❑
Epilepsy	❑	Fibromyalgia	❑	German Measles	❑	Headache	❑
Heart Trouble	❑	Hepatitis	❑	Herniated Disk	❑	High Blood Pressure	❑
High Cholesterol	❑	HIV/ARC	❑	Kidney Disorder	❑	Loss of Bowel Control	❑
Lung Disease	❑	Menstrual Cramps	❑	Migraine Headaches	❑	Multiple Sclerosis	❑
Muscular Dystrophy	❑	Neck Pain	❑	Nervousness	❑	Numbness	❑
Osteoporosis	❑	Parkinson's disease	❑	Pinched Nerve	❑	Polio	❑
Poor circulation	❑	Reproductive disorder	❑	Rheumatic Fever	❑	Rheumatism	❑
Rheumatoid Arthritis	❑	Scarlet Fever	❑	Scoliosis	❑	Serious Injury	❑
Sinus Trouble	❑	Stroke	❑	Thyroid Problems	❑	Tuberculosis	❑
Tumors or Growths	❑	Ulcers	❑	Venereal Disease	❑	_____	❑

SYMPTOMS			
On the following pages you will be asked to choose your symptoms from this list.			
Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain
Left Shoulder Pain	Right Shoulder Pain	Left Hip Pain	Right Hip Pain
Left Knee Pain	Right Knee Pain	Left Leg Pain	Right Leg Pain
Stiff Neck	Headache	Left Hand Pain	Right Hand Pain

IMPAIRED ACTIVITIES			
To go with each symptom you are reporting, you will be asked to select the MAIN activity that is made more difficult by each symptom. Choose the activity out of the options below.			
Computer Use (extended)	Computer Use (Short time)	Concentrating	Cycling
Desk Work	Drawing	Driving	Exercise
Lying Down	Piano	Reading	Running
Sitting	Standing	Staying Asleep	Using the Phone
Walking	Yard Work	Bathing	Bending
Caring for Infirm Person	Cervical Range of Motion	Child Care	Climbing Stair
Falling Asleep	Dressing	Golf	Hair Care
Kneeling	Lifting	Lifting Children	Lifting/Carrying Groceries
Looking over Shoulder	Lying Down	Needlework	Pet Care

Please fill out the form below to describe your current symptoms.

SYMPTOM 1

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Mode of onset and duration:

Onset Date ____/____/_____

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality:
❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

Pain Frequency:
❑Constant
❑Frequent
❑Intermittent
❑Occasional
❑Rare

Pain Pattern:
❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent
❑Unchanged

Pain radiates into:
❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other: _____

What has been done before to treat this symptom?
❑Acupuncture ❑ Prescription medicine
❑Massage
❑ Surgery
❑OTC Medicines

Pain Cause:
❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset
Explain:_____
_____
_____
_____

Pain Duration:
❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

Pain aggravated by:
❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

Pain relieved by:
❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head

Previous episodes of the same or similar condition and when occurred:

Doctors and previous treatment for this problem: