Patient Intake Form

Name: _____

Are your present problems due to an injury? ❑Yes ❑No

Enter the date of the injury:_____

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No

If so, to whom? ❑To Employer ❑Auto Carrier ❑Other:_____

BRIEFLY DESCRIBE THE PAIN AND SYMPTOMS FOR WHICH YOU ARE NOW CONSULTING US:

_____

_____

_____

_____

_____

LIST ANY TESTS, STUDIES OR MEDICATIONS RECEIVED FOR THIS CONDITION:

❑Tests/Studies: _____

❑Medications: _____

Were you treated at the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? _____ Transported by? ❑Ambulance ❑Police ❑Other

Date Admitted: _____ Date Released: _____ Length of Stay: _____

HABITS

- ❑ Smoking: packs/day_____
- ❑ Drinking Alcohol: cups/day____
- ❑ Coffee: cups/day____
- ❑ Soft Drink: cans/day____
- ❑ Water: cups/day____

EXERCISE

- ❑ None
- ❑ Moderate
- ❑ Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother:	❑	❑	❑	❑_____
Father:	❑	❑	❑	❑_____
Brother(s):	❑	❑	❑	❑_____
Sister(s):	❑	❑	❑	❑_____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc?

❑Yes ❑No If yes, which ones?: _____

PLEASE CHECK THE BOX FOR EACH CURRENT OR PAST SYMPTOM LISTED.

GENERAL SYMPTOMS

- ❑ Allergy (wheat)_____
- ❑ Bronchitis
- ❑ Headache
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness in _____
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder
- ❑ Hemorrhoids (piles)
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools

EYE/EAR/NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Urination Control
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ❑ Appendicitis
- ❑ Arthritis
- ❑ Goiter
- ❑ Mumps
- ❑ Polio
- ❑ Lumbago
- ❑ Alcoholism
- ❑ Cancer
- ❑ Anemia
- ❑ Pneumonia
- ❑ Epilepsy
- ❑ Influenza
- ❑ Chicken Pox
- ❑ Tuberculosis
- ❑ Eczema
- ❑ Venereal Disease
- ❑ Heart Disease
- ❑ Measles
- ❑ Rheumatic Fever
- ❑ Mental Disorder
- ❑ Pleurisy
- ❑ Diabetes
- ❑ Whooping Cough
- ❑ HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic and/or medical health care, and I give authority for these procedures to be performed. It is understood and agreed the x-ray imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____