Chiropractic Health Management: Patient Intake Form

Patient Information

Name: _____ Date of Birth: _____

Age: ____ Sex: _____ Marital Status: Single Married Divorced Widowed

Occupation: _____ Employer Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Work Phone: _____

Referred by: _____

Have you had chirorpractic care in the past? Yes No

Emergency Contact: _____

Insurance Information

Insurance Company: _____ Group/Claim#: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim Representative: _____ Phone: _____

Responsible Party: _____ Policy/ID Number: _____

Are your current problems due to an injury? Yes No

If not, please state the reason: _____

If yes, where were you injured (back, neck, etc)? _____

Has the accident or injury been reported? If so, to whom? _____

Are you now or have you ever been disabled? If so, when? _____

Have you retained an attorney? If so, what is the name and address?

Name: _____ Address: _____

If anyone in your immediate family has any of the following conditions, please explain.
Diabetes, heart condition, kidney disease, cancer, back problems, arthritis, major surgeries, digestive issues

_____

_____

Have you had any of the following diseases? Please circle those that apply:

Appendicitis	Anemia	Heart disease	Arthritis
Pneumonia	Measles	Goiter	Epilepsy
Rheumatic Fever	Mumps	Influenza	Mental disorder
Polio	Chicken Pox	Pleurisy	Lumbago
Tuberculosis	Diabetes	Alcoholism	Eczema
Whooping Cough	Cancer	Venereal Infection	AIDs

Please circle any of the following signs and symptoms that apply to your health. A complete history and understanding of your health will help us help you.

General Symptoms:

headache	dizziness	fever	fatigue
head feels heavy	weight loss	loss of sleep	nervousness
light headed	fainting	light bothers eyes	convulsions
loss of smell	loss of taste	loss of balance	loss of hearing
irritability	allergies		

If you circled allergies, please list all of them: _____

Neck:

neck pain	pain w/ movement	pitched nerve	stiffness
muscle spasms	grinding sounds	popping sounds	arthritis

Back:

back pain	pinched nerve	muscle spasms	arthritis
slipped disc	feels out of place	pain between shoulders	

back pain is worse when:

a) working b) lifting c) stooping d) standing e) sitting f) coughing

Shoulders:

pain in joints	pain across shoulders	bursitis	arthritis
unable to raise arm	muscle spasms		

Arms and Hands:

pain in fingers	pain in hands	pain in upper arms	pain in forearm
stabbing pains	cold hands	loss of strength	swollen joints in fingers
numbness	tingling		

Hips, Legs and Feet:

buttock pain	hip pain	knee pain	foot pain
pain down leg	cold feet	swollen ankles	numbness
tingling			

Cardiovascular:

chest pain	difficulty breathing	pain around ribs	rapid/slow heart rate
poor circulation	high/low blood pressure		

Gastro-Intestinal:

poor appetite	poor digestion	excessive hunger	belching
gas/nausea	vomiting	vomiting blood	pain over stomach
constipation	colon trouble	liver trouble	jaundice
gallbladder trouble			

Eyes, Ears, Nose and Throat:

poor vision	eye pain	deafness	ear ache
ear discharge	ringing in ears	buzzing in ears	nasal obstruction
nose bleed	sore throat	hoarseness	asthma
frequent cold	sinus trouble		

Skin Allergies:

itching	dryness	bruise easily	sensitive skin
hives	eczema		

Genito-Urinary:

frequent urination	painful urination	blood in urine	kidney infection
prostate trouble	inability to control urination		

Respiratory:

chronic cough	spitting blood	spitting phlegm	chest pain
difficulty breathing			

Women Only:

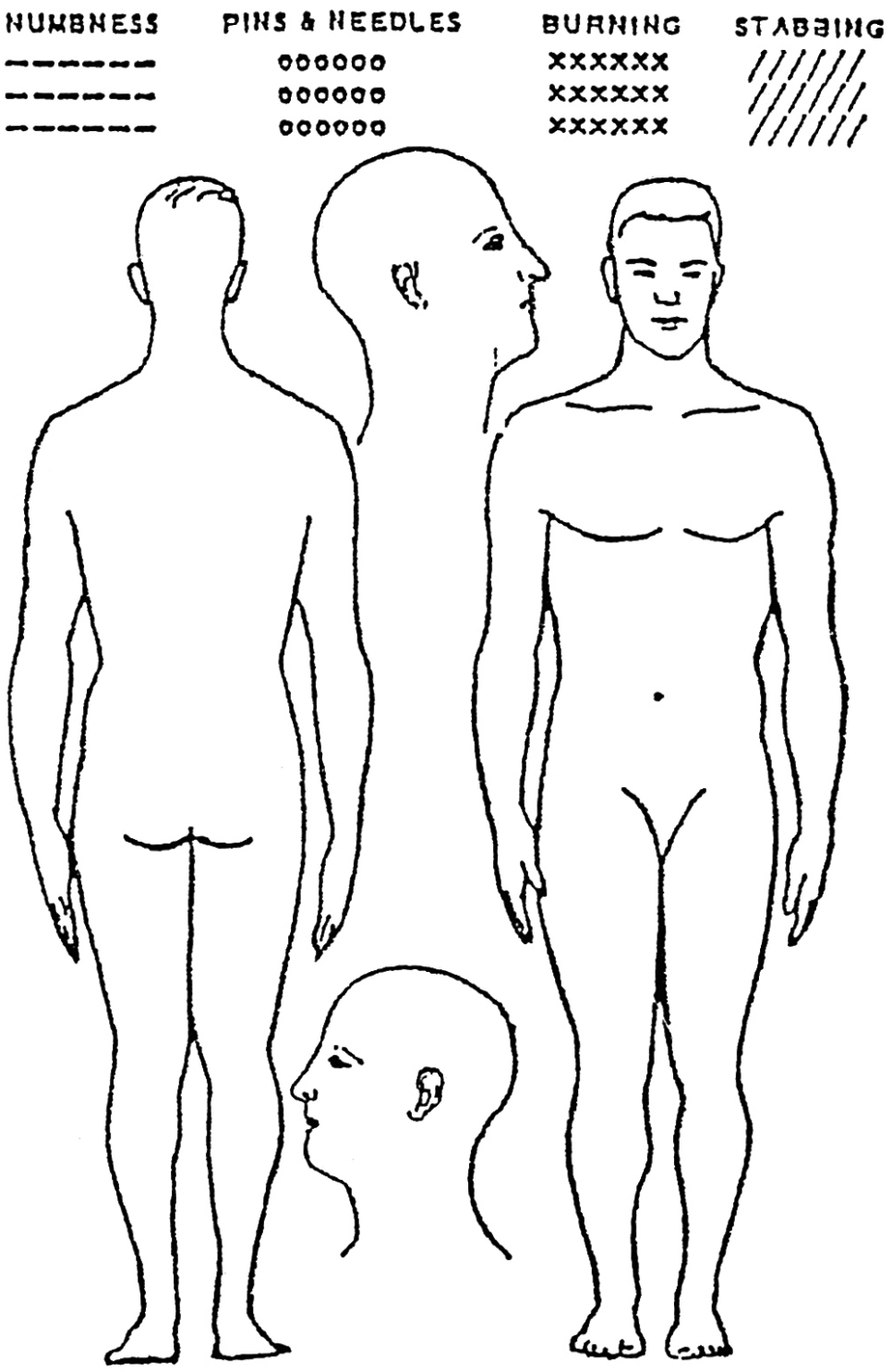
painful periods	excessive flow	irregular cycle	hot flashes
cramps	vaginal discharge	currently pregnant	

Doctor's Use Only: _____

_____

_____

Please mark area(s) of pain in the drawing below:



Operations, Procedures, and Hospitalizations:

Please list all relevant information.

_____

_____

_____

Please list any accidents or injuries as well as the dates of these incidents. Specify if the injury was sustained from auto, work, sports or other.

_____

_____

_____

List any broken/fractured/dislocated bones.

_____

_____

Have you ever had x-rays taken? If so, why, when and by whom?

_____

_____

_____

Do you suffer from any other conditions other than that for which you are consulting this office?

_____

_____

_____

Are you presently taking any medications (specify prescription, over the counter or both)?

_____

_____

_____

Signature: _____ Date: _____