

<b>PATIENT'S NAME:</b>	<b>Insured's Name:</b> <input type="checkbox"/> Same as Patient <b>OR</b>
FIRST: _____	FIRST: _____
MIDDLE: _____	MIDDLE: _____
LAST: _____	LAST: _____
PATIENT'S BIRTH DATE: ____/____/____	INSURED'S BIRTH DATE: ____/____/____
PATIENT'S GENDER: M <input type="checkbox"/> F <input type="checkbox"/>	INSURED'S GENDER: M <input type="checkbox"/> F <input type="checkbox"/>
PATIENT'S SSN: _____	INSURED'S SSN: _____
STREET: _____	STREET: _____
CITY: _____	CITY: _____
STATE: _____ ZIP CODE: _____	STATE: _____ ZIP CODE: _____
TELEPHONE: _____	TELEPHONE: _____
CELL NUMBER: _____	CELL NUMBER: _____
EMAIL ADDRESS: _____	
REFERRED BY: _____	

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: SELF  SPOUSE  CHILD  OTHER

PATIENT STATUS: SINGLE  MARRIED  OTHER  IF MARRIED, ANNIVERSARY DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYED  FULL-TIME STUDENT  PART-TIME STUDENT

IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT? (CURRENT OR PREVIOUS)  YES  NO

AUTO ACCIDENT?  YES  NO PLACE (STATE): \_\_\_\_\_

OTHER ACCIDENT?  YES  NO

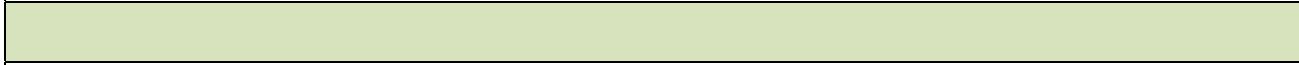
MEDICARE MEDACAID CHAMPUS CHAMPVA GROUP HEALTH PLAN OTHER: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION** **IS THERE ANOTHER HEALTH BENEFIT PLAN?**  YES  NO

ID NUMBER: \_\_\_\_\_ POLICY GROUP OR FECA NUMBER: \_\_\_\_\_

EMPLOYER'S NAME OR SCHOOL NAME: \_\_\_\_\_

INSURANCE PLAN NAME OR PROGRAM TYPE: \_\_\_\_\_



**WHAT ARE YOUR WELLNESS GOALS?**

\_\_\_\_\_

\_\_\_\_\_

**HAVE YOU LOST THE ABILITY TO DO SOMETHING YOU WOULD LIKE TO REGAIN? \_\_\_\_ YES \_\_\_\_ NO IF YES, PLEASE LIST:**

\_\_\_\_\_

**HERE IS A LIST OF THINGS CHIROPRACTIC, MASSAGE AND YOGA CAN HELP WITH. Please circle the ones that apply to you:**

STRESS RELIEF    PAIN RELIEF    BETTER BREATHING    FLEXIBILITY    INCREASED STRENGTH

WEIGHT MANAGEMENT    IMPROVED CIRCULATION    CARDIOVASCULAR CONDITIONING

BETTER BODY ALIGNMENT    FOCUS ON THE PRESENT

**WHAT CHALLENGES DO YOU HAVE OR WANT TO OVERCOME?**

\_\_\_\_\_

\_\_\_\_\_

**ARE THERE CERTAIN MOTIONS OR POSTURES YOU NEED TO AVOID OR THAT ARE PAINFUL OR UNCOMFORTABLE? \_\_\_\_ YES \_\_\_\_ NO**

**IF YES, PLEASE LIST AND EXPLAIN:**

\_\_\_\_\_

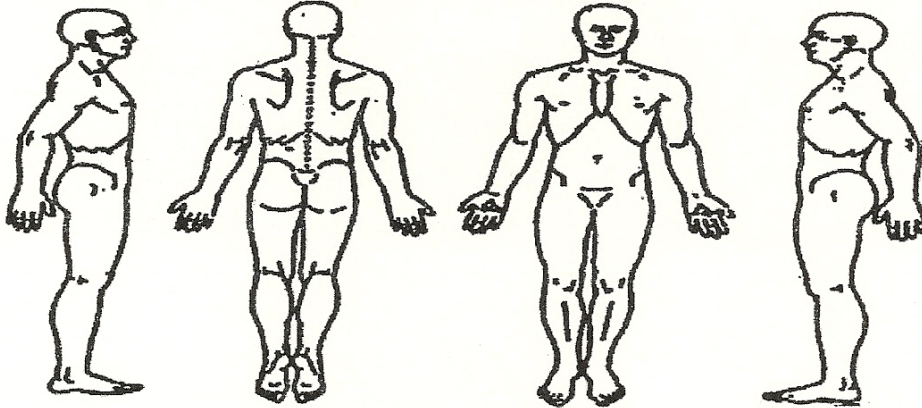
\_\_\_\_\_

# Patient Intake Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp  Numb  Dull  Tingly  Diffuse  
 Sharp with motion  Achy  Shooting with motion  Burning  
 Stabbing with motion  Shooting  Electric like with motion  Stiff  
 Other: \_\_\_\_\_

5. How are your symptoms changing with time?  Getting Worse  Staying the same  Getting Better

6. Using a scale from 1-10 (10 being the worst), how would you rate your problem? (Please circle.)

0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

9. Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician  
 ER physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  No one

Recent  X-rays  MRI  CT  Lab work taken Date taken: \_\_\_\_\_ Location: \_\_\_\_\_

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began? \_\_\_\_\_

12. Do you consider this problem to be severe?  Yes  Yes, at times  No

13. What aggravates your problem? \_\_\_\_\_

What helps your problem? \_\_\_\_\_

14. What concerns you the most about your problem; what does it prevent you from doing? \_\_\_\_\_

15. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

16. Occupation: \_\_\_\_\_

17. How would you rate your overall health?  Excellent  Very Good  Good  Fair  Poor

18. What type of exercise do you do?  Strenuous  Moderate  Light  None

19. Indicate if you have any immediate family members with the following:

- Rheumatoid Arthritis  Diabetes  Lupus  
 Heart Problem  Cancer  ALS  Other: \_\_\_\_\_

20. For each of the conditions listed below, place a check in the “past” column if you have had the condition in the past. If you presently have a condition listed below, place a check in the “present” column.

	Yes Past	Yes Current		Yes Past	Yes Current
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight		
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder		
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Tumor, Cysts, Lipomas	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<b>For Females Only:</b>		
Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>

21. List all prescription medications you are currently taking and what condition for: \_\_\_\_\_

22. List all of the over-the-counter medications, supplements and/or herbs you are currently taking and why: \_\_\_\_\_

23. List all surgical procedures you have had and when they occurred: \_\_\_\_\_

24. What activities do you do outside of work/hobbies? \_\_\_\_\_

25. Have you ever been hospitalized?  Yes  No

If yes, why and when: \_\_\_\_\_

26. Have you had significant past trauma (fractures, falls, motor vehicle accidents, etc.)?  Yes  No

Please explain. \_\_\_\_\_

27. Anything else pertinent to your visit today? \_\_\_\_\_

Are you under the care of another physician/provider for any of the above or other conditions?  Yes  No

If yes, please list name and facility: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature if Patient is a Minor: \_\_\_\_\_ Date: \_\_\_\_\_