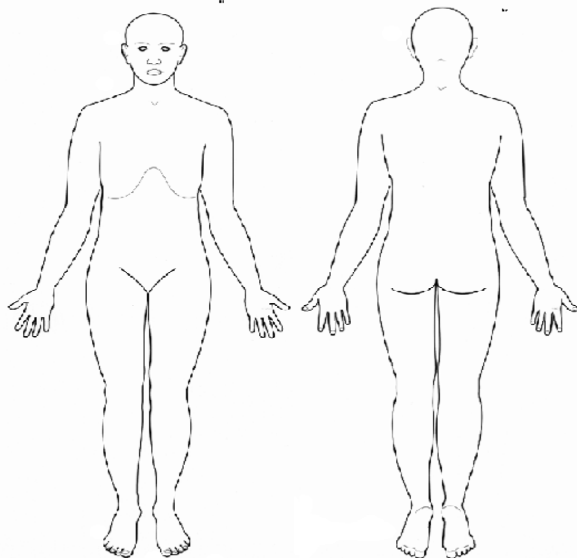
New Patient Intake Form

First Name ___________________ Middle Initial ____ Last Name __________________________
Address ____
City _______________________________ State ___________________ Zip Code ______________
Home Phone (_____) ________-___________ Cell Phone (_____) ________-____________
Email ____
Date of Birth _____/_____/______ **Sex:** ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Other **Children:** Yes No
Ages:_______________
Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____
Emergency Contact
Contact Name ____________________________ Relationship to Patient ___________________
Contact Phone (_____) _______-________

Would you like us to verify your health insurance coverage? Yes No
How did you hear about our office? ____
Do you have a primary complaint?____
When and how did it begin? ____
What makes it better?_________________________________Worse? ________________________
(*Women Only) Are you pregnant? Yes_____ No ______Uncertain______



Please mark on the diagram where your pain is occurring.
If you are currently experiencing pain, is it: (*Mark all that apply*)
Sharp _____ *Dull Ache* _____ *Burning* _____
Throbbing _____ *Stabbing* _____ *Shooting* _____
Numbness _____ *Tingling* _______
Does the pain: Come and go Constant
How often does the pain occur? *Hourly*___
*Daily*___ *Weekly*___ *Occasionally*___ *N/A*___
If the pain travels, where does it go?____
How would you rate your pain? (0 = no pain, 10 = worst pain possible): 0 1 2 3 4 5 6 7 8 9 10

Since the onset, has the complaint? *Improved*___
*Worsened*___ *Stayed the same*___ *N/A*___

Is this keeping you from...
*Working*___ *Exercising*___ *Sports/hobbies*___ *Driving*___ *Sleeping*___ *Family Time*___

How would you rate your HEALTH right now? (0 = Unhealthy, 10 = Optimum Health)
0 1 2 3 4 5 6 7 8 9 10
Have you ever been under chiropractic care? If so, when?
____

Following, is a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Mark the following conditions that are CURRENTLY a cause of significant concern.

Current Significant MUSCULOSKELETAL concerns:___________________________________

Back/Neck Pain____ Carpal Tunnel____ Scoliosis____ Joint Pain_____
Leg Pain/Sciatica____ Headaches___ Arthritis____ Swollen Join____

Current Significant CARDIOVASCULAR concerns:______________________________________

Chest Pain/Angina______ Blood Pressure Issues______ Anemia________ Cold Extremities_____
Varicose Veins_____ Heart Problems _______ Arterio/Athero Sclerosis_____ Stroke______

Current Significant GASTRO-INTESTINAL concerns:___________________________________

Abnormal Appetite_____ Nausea_____ Constipation_____ Bad Breath_____ Ulcers_____
Increased Thirst_____ Vomiting_____ Bloating/Gas_____ Heartburn_____ Diarrhea_____
GERD/Acid Reflux_____ Gall Stones_____

Current Significant URINARY/REPRODCUTIVE concerns:________________________________

Kidney Infection_____ Bladder Trouble_____ Fibroid_____ Hot Flashes_____ Cramps_____
Cysts_____ Impotence_____ Kidney Stones_____ Frequent Urination_____ PMS_____
Excessive Menstruation_____ Prostate Problems_____ Painful Urination_____ STD's_____
Decreased Sex Drive_____ Painful Menstruation_____ Endometriosis_____ Pregnant_____
Discolored Urination_____ Hemorrhoids_____

Current Significant NERVOUS SYSTEM concerns:______________________________________

Nervousness_____ Shooting Pain_____ Seizures_____ Dizziness/Vertigo_____ Anxiety_____
Paralysis_____ Loss of Balance_____ Loss of Taste_____ Numbness/Tingling_____
Forgetfulness_____ Loss of Smell_____

Current Significant GENERAL concerns:____

Allergies_____ ADD/ADHD_____ Diabetes_____ Herpes Zoster/Simplex_____ Fatigue_____
Colic_____ Autism_____ Hearing_____ Insomnia_____ Lung Problems_____ Dental_____
Heart Disease_____ Depression_____ Cancer_____ Chicken Pox_____ Vision_____

List All Current Medications (include all over-the-counter, supplements, and herbs):____________________________________
____
____
____
____

List any accidents or traumas, when they happened, and what was injured:____________________________________
____
____
____
____

List any major surgeries:
____

Name of Primary Care Physician and Approx. Date of Last Visit: ____________________________
Have you been treated for any conditions in the last year? Yes No
If yes, please explain:____
Please include any additional information, concerns, or questions you would like to add:____
____

The statements made as to the questions asked on this form are accurate to the bets of my knowledge and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form and in the file will remain confidential to myself, the doctor, and any other authorized personnel. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

Signature________________________________ **Date**_____________________________