Today's Date (month/day/year): ______/______/________
Z#: __________

PATIENT INTAKE FORM: ADULT

CONTACT INFORMATION:

First Name: _________________________ Middle Name: __________________ Last Name: ______________________________

Address: ____

City: __________________________________ State: __________ Zip: ____________________

SS#: ______-______-________ DOB: ____/____/________

Please circle one: Gender: M F Marital Status: Single Married Widowed Divorced Legally Separated

Spouse's name _______________________

Home Phone #: (____)______-_______ Cell #: (____)______-_______ Work Phone #: (____)______-_______

Contact Preference:_________________ Do you want text reminders for your appointments?_________________

Home E-mail: ___________________________ How did you hear about our office OR who referred you? ___________________

Emergency Contact: ______________________________ Relationship: ____________________ Ph: (______)______-________

Do we have permission to discuss scheduling/appointments with emergency contact? Yes or No

Do we have permission to discuss financial amount owed or credit with emergency contact? Yes or No

PRIMARY CARE PHYSICIAN:

First Name: ______________________________ Last Name: ______________________________ Group: __________________

Doctor's Address: ____

City: __________________________________ State: __________ Zip: ____________________

EMPLOYER DATA:

Employer: ____ Occupation: ______________________________

Employer's Address: ____

City: __________________________________ State: __________ Zip: ____________________

Primary Phone #: (______)______-________ Secondary Phone #: (______)______-________ Fax #: (______)______-________

GUARANTOR INFORMATION:

Do you have health insurance? • Yes • No *(If yes, go on to the next line)*

Who is responsible for the health insurance? • Patient • Spouse • Parent/Guardian • Other *(If patient, skip to next section)*

First Name: ________________________ Middle Name: _________________ Last Name: _____________________________

Address: ____

City: _________________________________ State: __________ Zip: ____________________

Home Phone #: (______)______-________ Secondary Phone #: (______)______-________ Cell #: (______)______-________

DOB: ____/____/________ SS#: ______-______-________ Gender: • M • F

I have been provided a copy of the terms of acceptance, consent to use and disclosure of protected Health Information, as well as appointment policies for this office.

Patient Signature:____ Today's date:______________________________

INSURANCE INFORMATION: *(If you have health insurance present your benefit card to the front desk staff with this completed form)*

PATIENT HISTORY & CONSULTATION:

Describe the health concern you are experiencing: ____

____

____

How long have you been suffering with this? ____

What do you think caused your health complaint? ____

____

Is this health concern related to a worker's compensation injury or a No Fault injury (car accident): Yes or No

If yes, what was the injury and when? ____

Have you ever experienced this before? ____

What makes your problem worse? ____

Does anything improve your problem? ____

How has this health concern altered your Quality of Life? ____

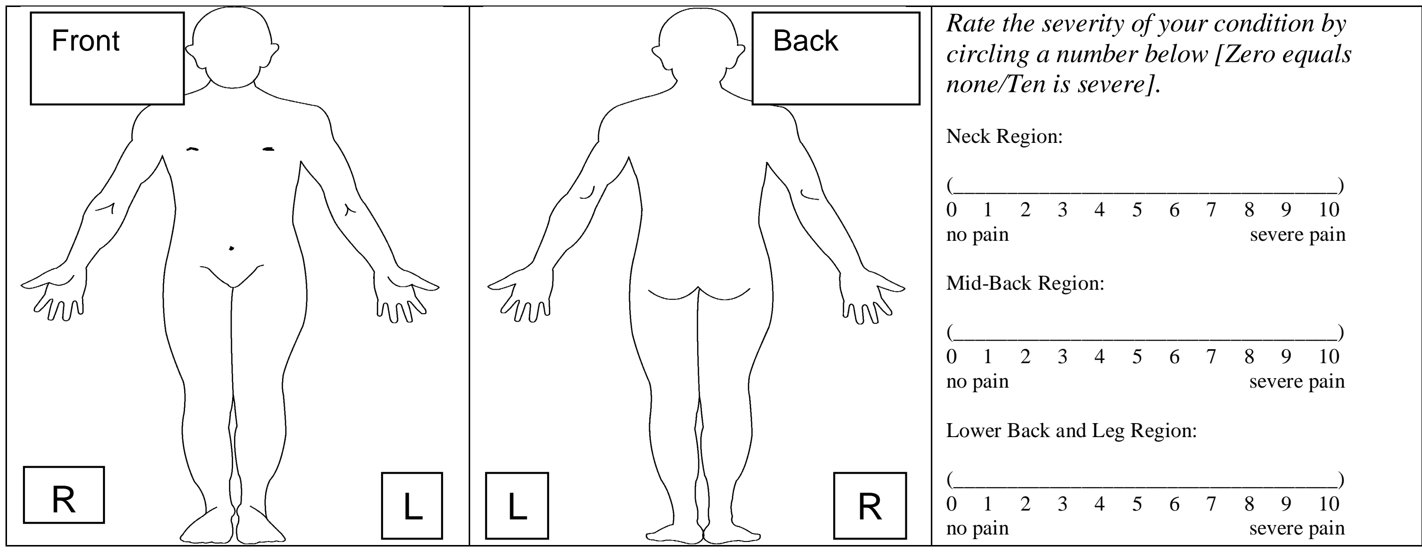
____

Please list all other chiropractors/medical doctors/physical therapists that you have seen for this complaint: Have not seen anyone

1. ______________________ 2. ______________________ 3.______________________

Have you had any diagnostic tests performed for this complaint? (circle one) X-rays CT Scan MRI Nerve Testing (EMG) Other

PATIENT DIAGRAM: *(Please circle the area(s) that are bothersome and show any radiation of pain/symptoms with an arrow)*



Office use ONLY – Condition(s): 1. __________ 2. __________ 3. __________ 4. __________IV_____OV______

PATIENT HISTORY & CONSULTATION:

Do you have any children?   Yes   No [Please list name(s) and ages]

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

Do you smoke?   Yes No How much? ____________ Alcohol consumption?   Yes   No How much? ____________

Coffee/Caffeine consumption? Cups/day: ____________ Do you Exercise regularly?   Yes   No How much? ____________

Describe your daily stress on a scale of 0-10. (0=no stress, 10=extreme): Occupational: __________ Personal: __________

Please list anyone in your immediate family that has suffered from any of the following conditions, including yourself:

Heart Disease______________ High/Low Blood Pressure ______________ High Cholesterol ______________

Stroke ______________ Asthma/Bronchitis/Pneumonia______________________________

Cancer ______________________________ Bowel Disease ______________________________

Diabetes ______________ Chemical Dependency ______________ Psychiatric Care ______________

Check symptoms you have noticed this year:

•Headache	•Irritability	•Numbness in Toes	•Face Flushed	•Cold Hand
•Constipation	•Neck Pain	•Chest Pain	•Shortness of Breath	•Ringing in Ears
•Upset Stomach	•Cold Sweats	•Dizziness	•Cold Feet	•Fainting
•Stiff Neck	•Fatigue	•Head seems Heavy	•Depression	•Loss of Memory
•Sleeping Problems	•Light sensitive	•Numbness in Arms	•Pins & Needles in arms	•Nervousness
•Back Pain	•Diarrhea	•Numbness in Hands	•Pins & Needles in legs	

Please list all of your hospitalizations. Include the year and reason for each visit (i.e. surgery, ER)

1. ______________________ 4.______________________

2. ______________________ 5.______________________

3. ______________________ 6.______________________

Please list the medications you are currently taking:

1. ______________________ 4.______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

Have you noticed any recent weight loss or gain?   Yes   No   How much over what period of time? ______________

Females: Date of your last menstrual period? ______________ Are you pregnant? ______________

Date of your last breast examination? ______________ History of breast lumps? ______________

Males: When was your last prostate examination? ______________________________