Patient Intake Form

Date:__________

Name: First__________________Middle__________________Last______________

Called name:_______________________________________Sex: Male Female:

Birthdate:____________Martial Status: Single, Married, Divorce, Other:__________

address:____

City:_______________State:______Zip Code______Height______Weight_______

Homephone:____________Workphone__________CellPhone_______________

Email address:____

Work Status: Employed, Not Employed, Student, Retired, Other:________________

Race: American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, White, Declined to State:

Ethnicity: Decline to State, Hispanic or Latino, Not Hispanic or Latino

Briefly describe why you are in our office:

____

____

____

List symptoms experienced : Choose the severity associated with the symptom

_____________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe

_____________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies:____

❑Medications:____

____

____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: ____________

____

Do you have allergies to medication? ❑Yes ❑No If yes, which ones?: ______________

____

Do you suffer from any condition other than that for which you are now consulting us?
❑Yes ❑No

If yes please explain:____

____

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)	❑	❑	❑	❑

If you quit smoking: When did you quit?_____

OPERATIONS AND PROCEDURES

Have you ever had any surgeries? ❑Yes ❑No (If yes, enter type and approximate date of surgery.)_____

Have you ever had X-rays/MRI/CT Scan taken? ❑Yes ❑No When?_____

GENERAL SYMPTOMS ❑ **Loss of Sleep**

❑ **Nervousness** ❑ **Loss of Weight**

❑ **Night Sweats** ❑ **Numbness in** _____

RESPIRATORY

❑ Allergy(What) _____
❑ Bronchitis
❑ Chronic Cough ❑ Headache
❑ Spitting Blood ❑ Convulsions
❑ Spitting Phlegm ❑ Dizziness
❑ Fainting
❑ Wheezing

GASTRO-INTESTINAL

❑ Belching or Gas ❑ Asthma
❑ Colon Trouble
❑ Constipation
❑ Diarrhea
❑ Gall Bladder
❑ Hemorrhoids (piles)

EYE/EAR/NOSE/THROAT

❑ Chest Pain
❑ Deafness
❑ Earache
❑ Ear Discharge
❑ Ear Noises
❑ Thyroid

GASTRO-INTESTINAL

❑ Nausea
❑ Stomach Pain
❑ Vomiting
❑ Vomiting Blood
❑ Heart Burn
❑ Bloody Stools

EYE/EAR/NOSE/THROAT

❑ Nasal Obstruction
❑ Nose Bleeds
❑ Pain in Eyes
❑ Poor Vision
❑ Blurred Vision
❑ Sinusitis

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	❑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 Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

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