Patient Confidential Health Record—Intake Form

Please Take A Moment To Fill Out The Following:

Name ________________________ Social Security # ________________ Date ____/____/________

Gender: M / F Age _____ DOB ________________ Email ______________________________

Address ______________________________ City ________________ State _____ Zip __________

Mobile # ________________ Home # ________________ Work # ____________________

Occupation ________________ Employer ______________ Referred By ____________________

Marital Status: Married Single Widowed Divorced Partnered Spouse's Name ____________________

Emergency Contact Name ____________________ Emergency Contact Number ____________________

Have you been to a chiropractor before? Y / N If yes, how did you respond? ____________________

Please Describe Your Presenting Condition And How It Began: **Date Problem Began:** ____/____/________

____

____

In the scale below, indicate the current intensity of your symptom(s). If the symptom level varies, please indicate a range of levels:

0	1	2	3	4	5	6	7	8	9	10
NO Symptoms										Worst Imaginable Symptoms

How often are your symptoms present?	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently
Describe your CURRENT pain/symptom(s):	☐ Sharp	☐ Throbbing	☐ Aching	☐ Stabbing
	☐ Dull	☐ Sore	☐ Weak	☐ Gripping
	☐ Numb	☐ Shooting	☐ Burning	☐ Tingling
	☐ Other:			
Since it began, is your symptom(s):	☐ Improving	☐ Getting Worse	☐ No Change	
What makes the symptom(s) better?	☐ Nothing	☐ Lying Down	☐ Walking	☐ Standing
	☐ Exercise	☐ Sitting	☐ Movement	☐ Inactivity
	☐ Other:			
What makes the symptom(s) worse?	☐ Nothing	☐ Lying Down	☐ Walking	☐ Standing
	☐ Exercise	☐ Sitting	☐ Movement	☐ Inactivity
	☐ Other:			
Can you perform your daily activities at home?	☐ Yes	☐ Yes, but with help	☐ Not at all	
Do you exercise?	☐ Intensely	☐ Frequently	☐ Occasionally	☐ Rarely/Never
Describe your job requirements:	☐ Sedentary	☐ Light labor	☐ Heavy labor	☐ Varies
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all	
Describe your stress level	☐ None to mild	☐ Moderate	☐ High	☐ Very High

Patient Signature: ______________________________ Date: ___/____/_______

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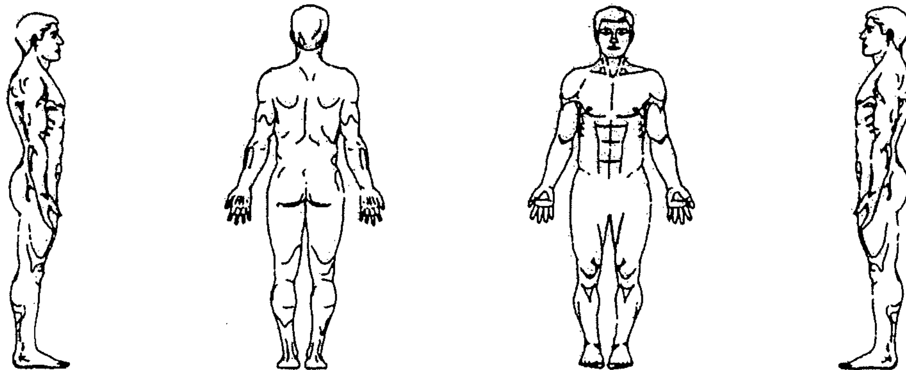
Pain Diagram: Please circle the area(s) where you have pain or other symptoms. Include symptoms of pain, numbness and/or tingling.



Review of Systems: If you have ever had a listed symptom in the past, please check that symptom in the *Past Column, "P"*. If you are presently troubled by a particular symptom, check that symptom in the *Current Column, "C"*. **Knowledge of these conditions may influence the type of treatment/therapy you receive.**

P C	**General**	P C	**G-I System**	P C	**Vascular**	P C	**Head**	P C	**Conditions**
☐ ☐	General Fatigue	☐ ☐	Ulcer	☐ ☐	Aortic Aneurysm	☐ ☐	Jaw Pain	☐ ☐	Cancer/Tumor
☐ ☐	Neck Pain	☐ ☐	Hepatitis	☐ ☐	Anemia	☐ ☐	Fainting	☐ ☐	Arthritis
☐ ☐	Shoulder Pain R / L	☐ ☐	Kidney/Gall Stone	☐ ☐	Angina	☐ ☐	Visual Disturbances	☐ ☐	Diabetes
☐ ☐	Pain in Upper Arm Or Elbow R / L	☐ ☐	Liver/Gallbladder Problems	☐ ☐	Heart Attack	☐ ☐	Convulsions	☐ ☐	Depression
☐ ☐	Hand Pain R / L	☐ ☐	Abdominal Pain	☐ ☐	Stroke	☐ ☐	Dizziness	☐ ☐	HIV/AIDS
☐ ☐	Wrist Pain R / L	☐ ☐	Kidney Disorders	☐ ☐	Rapid Heart Beat	☐ ☐	Headaches	☐ ☐	Thyroid Condition
☐ ☐	Pain in Upper Leg Or Hip R / L	☐ ☐	Prostate Problems	☐ ☐	Chest Pains	☐ ☐	Headache Unlike Ever Before	☐ ☐	Osteoporosis
☐ ☐	Pain in Lower Leg Or Knee R / L	☐ ☐	Difficulty Swallowing	☐ ☐	Blood Disorder	☐ ☐	Tinnitus (Ear Ringing)	☐ ☐	Alcoholism
☐ ☐	Pain in Ankle Or Foot R / L	☐ ☐	Heartburn Or Indigestion	☐ ☐	Ankle Swelling	☐ ☐	Head Trauma	☐ ☐	Polio
	Neurologic	☐ ☐	Loss of Appetite	☐ ☐	Cold Feet/Hands	☐ ☐	Dentures	☐ ☐	Parkinson's
☐ ☐	Epilepsy	☐ ☐	Anorexia	☐ ☐	High Blood Pressure	☐ ☐	Migraines	☐ ☐	Multiple Sclerosis
☐ ☐	Tingling Sensation	☐ ☐	Irritable Bowel	☐ ☐	Low Blood Pressure		**G-U System**	☐ ☐	Gout
☐ ☐	Numbness	☐ ☐	Colitis	☐ ☐	High Cholesterol	☐ ☐	Bladder Infection	☐ ☐	Psychiatric Care
☐ ☐	Weakness	☐ ☐	Excessive Thirst		**Female**	☐ ☐	Bladder Control Loss		**Lungs**
☐ ☐	Muscular Imbalance		**Skin**	☐ ☐	Endometriosis	☐ ☐	Painful Urination	☐ ☐	Emphysema
	Muscle/Bone	☐ ☐	Dermatitis/Eczema	☐ ☐	Profuse Menstrual Flow	☐ ☐	Frequent Urination	☐ ☐	Difficulty Breathing
☐ ☐	Swelling/Stiffness	☐ ☐	Rash	☐ ☐	Irregular Menstrual Flow	☐ ☐	Constipation/Irregular Bowel Habits	☐ ☐	Chronic Cough
☐ ☐	Muscle Ache	☐ ☐	Brittle Nails	☐ ☐	Breast Lumps	☐ ☐	Diarrhea	☐ ☐	Sinus Problems
☐ ☐	Fracture	☐ ☐	Changes In Moles	☐ ☐	Breast Soreness	☐ ☐	Constipation	☐ ☐	Wheezing
☐ ☐	Dislocation	☐ ☐	Peeling	☐ ☐	Birth Control Pills	☐ ☐	Blood in Stool	☐ ☐	Asthma

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Family History: Please check the boxes of the conditions that apply to your family.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Age of Onset	Description
Arthritis (type?)	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Cancer (type?)	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Lung Problems	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	________	____________________

Lifestyle Factors: Please complete the following information regarding your lifestyle.

Tobacco: _____ packs/day for _____ years Alcohol: _____ glasses/day Coffee/Tea/Caffeinated Soft Drinks: _____ glasses/day

Recreational Drugs: ____ Exercise: _____ hours/week Water: _____ glasses/day

Average Sleep Quality: _____ hrs. sleep/night My Sleep Is: ☐ Restful ☐ Restless ☐ Wake up often ☐ Hard to get sleep

Present Weight: _______lbs. Present Height: _________ I have had recent ABNORMAL: ☐ Weight Gain ☐ Weight Loss

Do you have a permanent disability rating? Yes/No Location: _________________ Rating: ____% Date Received: ____/____/_______

What treatment(s) have you had for this condition in the past (surgery, medications, injections, PT, chiropractic)?

____

Have you had X-rays, MRI or other tests for this condition? What tests and when?

____

Please list the medications you are currently taking:

____

____

Please list any reasons and dates for hospitalizations/surgeries: ______________________________________

____

General Understandings:

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I, the undersigned, consent to chiropractic care in this office.

I clearly understand and agree that I am responsible for payment of any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during treatment.

Regarding the national Health Information Portability and Accountability Act (HIPAA): All information that is obtained from you by this office is protected and kept confidential in accordance with HIPAA mandated standards. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced. Our HIPAA policy is not a contract, authorization, release, or form of consent. A copy of our HIPAA policies is presented to you at the time of your initial evaluation. You may request a paper or electronic version of these policies at any time. The signature below acknowledges that you have read and been offered a copy of this office's Notice of Privacy Practices.

Patient Signature: ____ Date: ___/____/_______

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