NEW PATIENT INTAKE FORM

Patient Name: _____ ***Occupation:*** _____ ***Age:*** ___ ***Date:*** _____

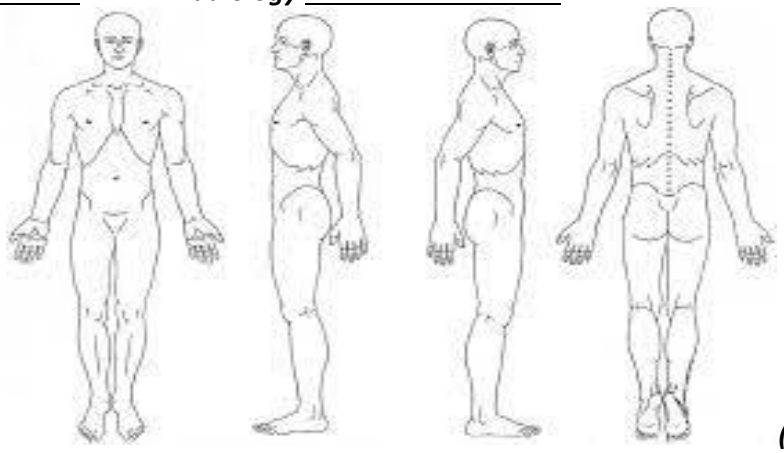
1. ***Describe your symptoms*** _____

   _____

   _____

2. ***Approximate date when symptoms began:*** _____
3. ***Probable cause of injury (if any):*** _____
4. ***Have you previously experienced a similar problem/injury? Yes____ No____***
   If yes, when? _____
5. ***Have you previously had treatment for this problem/injury? Yes____ No____***
   If yes, when? _____
6. ***Have you had any of the following related to this problem/injury?***
   Lab work _____ ***Radiology*** _____

Indicate painful areas with an "X"



(over)

FOR DOCTOR'S USE ONLY

1. Positions or actions of provocation _____
2. Positions or actions creating relief _____
3. Chronology of condition _____
4. Prior treatments that offer relief _____
5. Medications/procedures/surgeries that offer relief _____

   _____

6. Daily activities/work affected by problem _____
7. Other areas or injuries of concern _____
8. Any hospitalization/MVA/WC _____
9. Prior chiropractic _____
10. Pain scale 1 2 3 4 5 6 7 8 9 10

_____

_____

_____

NEW PATIENT INTAKE FORM (Page 2)

Current Medications _____ _____ _____ _____

_____ _____ _____ _____

Previous surgeries:_____

Do you exercise? Please describe:_____

MEDICAL HISTORY (Please circle all that apply)

Musculoskeletal • Osteopenia/Osteoporosis • Arthritis • Gout • Fibromyalgia • Disc injuries • Stenosis • Spinal trauma • Autoimmune disorder (i.e. RA) • Fractures/dislocations • Headaches • Joint replacement • Joint issues:_____ • Surgeries:_____ • Other:_____	**Gastrointestinal** • Abdominal surgery • Heartburn/Reflux • Chronic nausea • Constipation/diarrhea • Jaundice • Gut motility problems • Malabsorption syndrome • Ulcers • Gallbladder • Crohn's/ulcerative colitis • Surgeries:_____ • Other:_____	**Cardiovascular / Respiratory** • Heart attack • Open-heart surgery • Congestive Heart Failure (CHF) • High blood pressure • Low blood pressure • Clotting disorders • Peripheral vascular disease • Asthma • COPD • Chronic bronchitis • Emphysema • Surgeries: _____ • Other:_____
Neurological • Vertigo • Poor balance • Tremors • Seizures • Concussions • Head/neck trauma • Neurological disease (i.e. MS) • Surgeries:_____ • Other:_____	**Genitourinary** • Chronic UTIs • Kidney disease • Kidney stones • Excessive urination • Difficult or reduced urination • Incontinence • Gynecology issues • Surgeries:_____ • Other:_____	**Endocrine** • Diabetes • Neuropathy • Thyroid • Cold/heat intolerance • Excessive thirst • Liver disease • Surgeries: _____ • Other:_____
Eyes/ENT • Vision problems • Glaucoma • Macular degeneration • Sensitivity to light • Earaches • Tinnitus • Decreased hearing • Difficulty swallowing • Difficulty speaking • Surgeries:_____ • Other:_____	**Skin** • Excessive dryness • Chronic rash • Psoriasis • Eczema • Shingles • Cold sores • Skin cancers • Surgeries:_____ • Other:_____	**General** • Fatigue • Anemia • Memory loss • Anxiety/depression • Allergies • Bleeding/bruising disorder • Bursitis, tendinitis • Plantar fasciitis • Cancers:_____ • Surgeries: _____ • Other:_____

Other information or remarkable family history:_____

_____

Patient Signature:_____ Date: _____