Insert Logo Here

Patient Intake Form

Date ____________

First Name ____________
Last Name ____________
DOB ____________
Sex ◯ Male ◯ Female
SSN ____________
Address ____________
City ____________
State ____________
Zip Code ____________

Phone 1 ____________
◯ Mobile ◯ Home ◯ Work
Phone 2 ____________
◯ Mobile ◯ Home ◯ Work
Email ____________
Employer ____________
Employer Phone ____________
Occupation ____________

Marital Status
◯ Single ◯ Married ◯ Other

Working Status
◯ Employed
◯ Full-Time Student
◯ Part-Time Student

Reason For Visit ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury
◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other ____________

Referred By ◯ Provider ◯ Friend ◯ Family ◯ Other ____________
Referred By Name ____________

How Heard of Us ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website
◯ Advertisement ◯ Other ____________

Demographics

Race ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian or Other Specific Islander ◯ Other ____________

Ethnicity ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Other ____________

Dominance ◯ Right ◯ Left ◯ Ambidextrous

Insurance Information

Primary Insurance

Insurance Name ____________
Insurance Phone ____________
ID # ____________ Group # ____________
Insured First Name ____________
Insured Last Name ____________
DOB ____________

Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

OV Copay ____________
Deductible ____________ Applied ____________
Co-Ins ____________
VPY/MPY ____________
PCP Referral Required ◯ Yes ◯ No
Policy Effective Date ____________
Cal Yr / Other ____________
Other ____________

Emergency Contact Information

First Name ______________________ Relationship ______________________

Last Name ______________________ Phone 1 ____________ Phone 2 ____________

Health History

Medications/Vitamins/Supplements

Allergies

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Chicken Pox	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Allergy Shots	☐ Chronic Fatigue	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Anemia	☐ Depression	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Arthritis	☐ Diabetes	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Asthma	☐ Emphysema	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Bleeding Disorders	☐ Epilepsy	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Breast Lump	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Bronchitis	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Chemical Dependency	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other ____

Is there any history in your family for any of the above conditions?

Who? ____

What did they have? ____

Surgeries

Traumas

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Reason for visit: ______________________

Is there anything that makes your condition better? ______________________

Is there a time of day worse than others? ____________ Where specifically is the problem located? ____________

Frequency: ______ times per ◯ Day ◯ Week ◯ Month ◯ Year

Duration: Lasting ______ ◯ Minutes ◯ Hours

Onset: Have had symptoms over the past ______ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Moderate ◯ Slight ◯ Severe

Is your condition: ◯ Same ◯ Better ◯ Worse

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

How does your pain interfere with your daily activities (work, sleep, sex, etc.) ? ______________________

Have you been given a diagnosis for this problem? If so, what was the diagnosis? ______________________

What treatment(s) have you tried for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ Other ______________________

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? ______________________

If so, what conditions? ______________________

Date of your last physical exam: ____________ By whom? ______________________

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic

☐ Low (Time of Day) ____________ ☐ High (Time of Day) ____________

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other ______________________

Stress: ◯ None ◯ Moderate ◯ Severe What causes stress? ______________________

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? ________

Daily Habits

Do you smoke? ◯ Unknown if ever smoked ◯ Current status unknown ◯ Current every day smoker

◯ Current some day smoker ◯ Former smoker ◯ Never smoked

If yes, how many packs per day? ________ How many years? ________

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ Yes ◯ No Please describe ______________________

Review of Systems

Musculoskeletal: Please check all that apply

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations ☐ Persistent Coughing

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other ____________________

Head/Neck: Please check all that apply

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps

☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing

☐ Other ____________________

Eyes: Please check all that apply

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma

☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other __________

Ears: Please check all that apply

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing

☐ Ringing in ears (tinnitus) ☐ Other __________

Nose: Please check all that apply

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds

☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other __________

Throat/Mouth: Please check all that apply

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness

☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling

☐ Thrush ☐ Tooth pain ☐ Other __________

Urinary: Please check all that apply

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary track infections

☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)

☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other __________

Gastrointestinal: Please check all that apply

☐ Change in appetite ☐ Change in bowl habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea

☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other __________

Endocrine: Please check all that apply

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst

☐ Frequent urination ☐ Heat intolerence ☐ Sweating

Vascular/Hematologic: Please check all that apply

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness

☐ Worry/anxiety ☐ Other __________

Psychiatric: Please check all that apply

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other ____________

Female

Are you pregnant? ◯ Yes ◯ No Date of last period ________ Number of days between periods _____

Age started ______ Age stopped ______ Form of birth control ____________________

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other ____________

Male: Please check all that apply

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other ____________

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with ____________________
And assign directly to the above named Chiropractic clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named Chiropractic clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

______________________________________ Date __________

Signature of Patient, Parent, Guardian or Personal Representative

______________________________________ Date __________

Print Name of Patient, Parent, Guardian or Personal Representative

APPLICATION FOR TREATMENT

Name: ______________________________ DOB: _________ Date: _________ Doctor: ***Dr. Robin***

Referred by: ______________________________

Nature of Complaint

List the major complaints you would like addressed:

Rate the average pain scale (PS) after each item, on a scale of 0 to 10, with 0 = no pain and 10 = unbearable pain.

1 (Main) ______________________________ PS ____

2 ______________________________ PS ____

3 ______________________________ PS ____

4 ______________________________ PS ____

Please fill out Pain Drawing at right →

Use these symbols on drawing:
++++ Aching = = = Numbness
XXX Burning ///// Stabbing 000 Pins/Needles

History of Main Complaint

Do any of these complaints seem related? Y / N

When did this episode begin? ______________________________

Have you had similar symptoms before? Y / N

When? ______________________________

How did it occur? ☐ Gradually ☐ Suddenly

☐ No apparent reason ☐ Bending ☐ Lifting ☐ Fall

☐ Motor vehicle accident ☐ Work related

☐ Other ______________________________

Has Your Pain: ☐ Improved ☐ Worsened ☐ Not changed

Is Your Pain: ☐ Constant ☐ Intermittent: ☐ Daily ☐ Weekly

Does it interfere with? ☐ Work ☐ Sleep ☐ Daily routine

☐ Exercise ☐ Other ______________________________

What activity is limited most by pain? ______________________________

Do you have pain/numbness arms, legs, hands or feet? Y / N

Where and what type? ______________________________

How do the following affect your pain?

	Worse	Better	No change
Cough/sneeze	☐	☐	☐
Sitting	☐	☐	☐
Sit to Stand	☐	☐	☐
Bending forward	☐	☐	☐
Morning	☐	☐	☐
Lifting	☐	☐	☐
Bending backward	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lying on Stomach	☐	☐	☐
Nighttime	☐	☐	☐
Looking down	☐	☐	☐
Looking up	☐	☐	☐
Turning head	☐	☐	☐
Afternoon	☐	☐	☐
Evening	☐	☐	☐
Lying/rest	☐	☐	☐

For Doctor Use Only

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____