Dimensions Chiropractic

PATIENT INTAKE FORM

Patient Name: ____ Date: ____________________

Address: ____ Date of Birth: _______________

City: ________________________ State: _________ Zip: __________ Gender: Male Female

Phone (H): _________________ Phone (W): _________________ Phone (C): ________________

Social Security Number: __________________________ Email: _____________________________

Emergency Contact: ____________________ Relation: ________________ Phone: ____________

Referral (Who may we thank for referring you to our office?): _______________________________

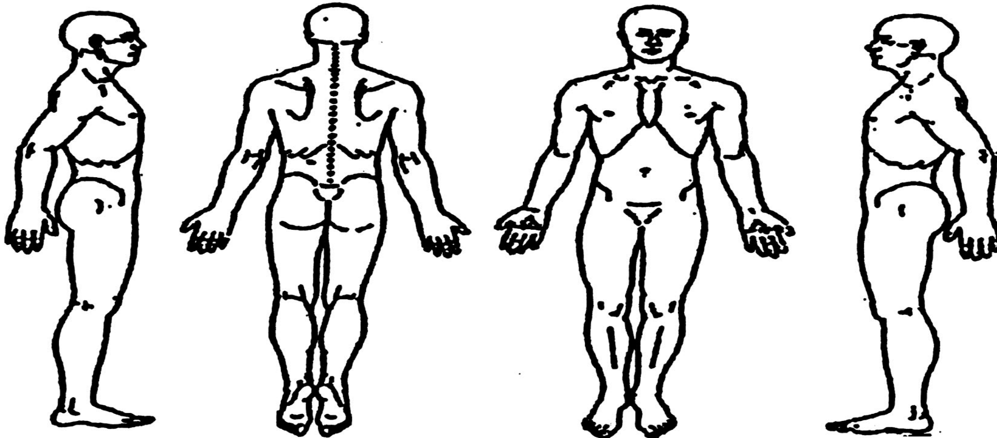
Financial and Insurance Information Do you have health insurance: YES NO

Name of Subscriber of Party Responsible for Payment: ____________________________________

Subscribers Date of Birth: _________________ Relationship: ______________________________

1. Is today's problem caused by: □ Auto Accident □ Worker's Compensation □ N/A

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other:____________________

5. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Have you seen a chiropractor in the past?
Chiropractor Name: ______________________________________ Dates: ______________________

Results: GREAT GOOD FAIR MIXED POOR Other:________________________________

Why did you discontinue care? ____

Who else have you seen for your problem?
□ Primary Care Physician Name: ____________________
□ Neurologist Name: ____________________
□ ER physician Name: ____________________
□ Orthopedist Name: ____________________
□ Massage Therapist Name: ____________________
□ Physical Therapist Name: ____________________
□ Other: ____

10. How long have you had this problem? ____________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

What alleviates your pain? ____

15. What is your: Height____________ Weight ______________ Date of Birth _______________

Occupation _______________________________________**# of hours worked/week:** ___________

Describe a typical work day: ____

____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ ALS □ Epilepsy
□ Heart Problems □ Cancer □ Auto-Immune Diseases (Lupus, MS, etc)

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorder	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gallbladder Disorder		No. of Pregnancies: ______
□	□ Cancer	□	□ General Fatigue		No. of Vaginal Births: ____
□	□ Tumor	□	□ Muscular Incoordination		No. of Cesareans: ________
□	□ Asthma	□	□ Visual Disturbances		Date of last menstrual
□	□ Chronic Sinusitis	□	□ Dizziness		period: ________________
□	□ Other:______________________________				Date of last Pap Exam: ____

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do daily:

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work (leisure, hobbies, sports, etc.)?

____

25. Have you ever been hospitalized? □ No □ Yes

If yes, explain: ____

26. Have you had significant past trauma? □ No □ Yes

If yes, explain: ____

Lifestyle

Hours of computer/tablet use daily? ______ Right/left handed? _______

Number of hours driving/day: ___________ Hours on your feet daily: ______

Hours of sleep each night (circle one): 0-2 3-5 6-8 9+

Is sleep (circle all that apply): restful restless hard to fall asleep wake up often

Do you smoke: yes no How much per day: _________________

How much alcohol do you consume weekly? _______________________

How much coffee/tea/caffeine do you consume daily? _______________

Daily water intake (circle one):

When I'm thirsty 2-4 glasses 5-8 glasses 9-12 glasses Constantly, I'm always thirsty

27. Are there any specific questions about your condition or chiropractic that you want Dr. Tammy or Dr. Kristen to address at today's visit?

____

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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to a third party and/or health practitioners. I authorize and request my insurance company to pay directly to Dimensions Chiropractic insurance benefits that are otherwise payable to me. I understand that my chiropractic insurance carrier may cover only a portion of or not cover all of services rendered.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

Patient Signature___________________________________ **Date:**_________________

Guardian Signature (if patient is a minor) ______________________ **Date:**_________________