# PATIENT INTAKE FORM

Today's Date: _____

Family Chiropractic Office
53 South Third St
Fulton, NY 13069

**PERSONAL INFORMATION**

Name: _____
FIRST LAST MI

Address: _____
STREET CITY ST ZIP

SS#: _____ Marital Status: S M D W Spouse's Name: _____

**Language:** ☐ English ☐ Spanish ☐ Other _____

**Race/Ethnicity:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic or Latino ☐ Hawaiian/Pacific Island Native ☐ White ☐ Other ☐ Declined to specify

Date of Birth: _____ Occupation: _____

Employer : _____

**VITALS:** Height: _____ft _____in. Weight: _____lbs

Do you smoke? Circle one: Never Former Smoker Current Every Day Smoker Current Some Day(s) Smoker Vape

**CONTACT INFORMATION:**

Home Phone ( ) _____ Work Phone ( ) _____ Ext _____

Cell Phone ( ) _____ Carrier ( )Verizon ( )AT&T ( )Sprint ( )Other _____

How would you prefer to be contacted? ☐ Home ☐ Work ☐ Cell

E mail: Home _____ Work _____

**Emergency Contact (Name, Ph#, Relationship)** _____

Did anyone refer you to our office? Yes / No If yes, who? _____

**IF THIS VISIT IS RELATED TO A WORK INJURY OR CAR ACCIDENT PLEASE LET THE FRONT DESK KNOW NOW!**

**INSURANCE INFORMATION** (*Please provide the front desk with a copy of your insurance card if you have not already done so)*

**Primary Ins:** _____ ID# _____ Group#: _____

Policy Holder's Name _____ SSN: _____ DOB: _____

Relationship to PT: _____ Employer: _____

**Secondary Ins:** _____ ID# _____ Group#: _____

Policy Holder's Name _____ SSN: _____ DOB: _____

Relationship to PT: _____ Employer _____

**PATIENT HEALTH HISTORY**

*Please give a brief description of the problems you are experiencing, beginning with **#1- the problem which brought you to our office today**. If this condition is the result of either a work-related injury or automobile accident, please see the front desk for additional paperwork. #2-3 Any other health issues you may have.*

#1 _____ Onset Date: _____

#2 _____ Onset Date: _____

#3 _____ Onset Date: _____

How did the problem (#1) start? _____

_____

Has this happened before? Yes / No If yes, when? _____

What (if anything) gives you relief? _____

Is this condition interfering with your work ☐ sleep ☐ daily routine ☐ other? _____

How long since you have felt really good? Years _____ Months _____ Weeks _____

Have you been treated by another doctor for this? MD ☐ DC ☐

Name of doctor(s): _____ Time in care: _____

Treatment: _____ MRI/CT/X-Rays: Yes / No Date: _____

Who is your **Primary Care Physician**? _____

Please answer **Yes** or **No**:

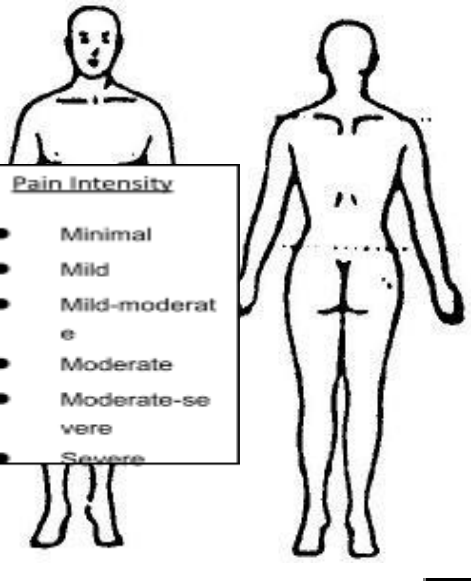
- Have you ever had cancer? _____ If yes, what type: _____
- Are you losing weight without trying? _____ If yes, how much: _____
- Does your pain wake you up at night? _____ If yes, how often: _____
- Have you had a change in bladder or bowel habits? _____ If yes, since when: _____
- Have you had a sore that doesn't heal? _____ If yes, where: _____
- Have you recently had any unusual bleeding or discharge? _____
- Do you have a thickening/lump in the breast or anywhere else? _____ Where? _____
- Have you had an obvious change in a wart or mole? _____
- Do you have a nagging cough or hoarseness? _____ If yes, for how long: _____

Cups of coffee and/or tea per day: _____ Alcohol drinks/day: _____ Pregnant? YES / NO / MAYBE

Do you exercise regularly? YES / NO Do you get headaches? YES / NO

Do you wear..? Circle, if yes: Heel Lifts Arch Supports Corrective Shoes

On the figures below, please shade in the area(s) of complaint, then place a check next to the appropriate word(s) that best describe(s) your problem(s).



**Pain Intensity**

- Minimal
- Mild
- Mild-moderate
- Moderate
- Moderate-severe
- Severe

**Onset**

- Acute
- Chronic
- Gradual
- Acute exacerbation of chronic condition

**Pain Quality**

- Achy
- Deep
- Burning
- Superficial
- Dull
- Shooting
- Sharp
- Tender
- Still
- Numbness/tingling
- Throbbing
- Itching
- Sore
- Immobilizing
- Aching
- Nauseating
- Localized
- Pins/needles
- Spread out
- stabbing
- Other

**Pain Frequency**

- Minimal
- Occasional (0-25%)
- Intermittent (26-50%)
- Frequent (51 – 75%)
- Constant (76-100%)
- Intermittent with occasional sharp pain
- Constant with occasional sharp pain

For your **primary** problem, circle the # on the scale which corresponds to your pain level for each question asked:

1. What is your pain level right now?

   0 1 2 3 4 5 6 7 8 9 10

2. What is your pain level at its worst (how close to ten does it get)?

   0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level when it is at its best (how close to zero does it get)?

   0 1 2 3 4 5 6 7 8 9 10

**What makes the pain worse?** (Circle all that apply)

Nothing / Driving / Lifting / Movement / Resting / Sleeping / Sitting / Standing / Walking / Working

Bending / Lifting / Twisting / Coughing / Sneezing / Gardening / Yard work / Getting out of bed /

Getting out of a chair / Staying in one position too long / Postural stress / Morning / Evening

Other _____

**What makes the pain better?** (Circle all that apply)

Nothing / Cold (Ice) / Chiropractic care / Massage / Medication / Movement / Resting / Sleeping /

Walking / Heat (Warmth) / Stretching / Exercise / Sitting / Standing / Morning / Evening

Other _____

**Please complete the following for any conditions you may be experiencing or have experienced: N=Now, P=Past**

| N | p | GASTRO-INTESTINAL |
|---|---|---|
| | | Constipation |
| | | Diarrhea |
| | | Digestive Problems |
| | | Stomach Pain |
| | | Vomiting Blood |
| | | Gall Bladder Trouble |
| | | Hemorrhoids |
| | | Liver Trouble |

| N | P | GENITO-URINARY |
|---|---|---|
| | | Frequent Urination |
| | | Painful Urination |
| | | Difficulty Starting Urine |
| | | Inability to control urine |
| | | Blood in urine |
| | | Bed Wetting |
| | | Kidney Infection |
| | | Prostate Trouble |

| N | P | CARDIO VASCULAR |
|---|---|---|
| | | High Blood Pressure |
| | | Low Blood Pressure |
| | | Poor Circulation |
| | | Previous Heart Trouble |
| | | Previous Stroke |

| N | P | RESPIRATORY |
|---|---|---|
| | | Chest Pains |
| | | Chronic Cough |
| | | Difficulty Breathing |
| | | Frequent Colds |
| | | Spitting of Blood |
| | | Allergies |

| N | P | EYES-EARS-NOSE |
|---|---|---|
| | | Eye Pains |
| | | Earaches |
| | | Ear Discharge |
| | | Ringing in Ears |
| | | Nasal Discharge |
| | | Nose Bleeds |
| | | Sinus Trouble |
| | | Trouble Swallowing |
| | | Hoarseness |
| | | Asthma |

| N | P | SKIN |
|---|---|---|
| | | Bruising |
| | | Boils |
| | | Dryness |

| N | P | MUSCLES AND JOINTS |
|---|---|---|
| | | Foot Problems |
| | | Swollen Joints |
| | | Hernia |

| N | P | FOR WOMEN ONLY |
|---|---|---|
| | | Cramps-Backache |
| | | Excessive Flow |
| | | Hot Flashes |
| | | Painful Intercourse |
| | | Painful Menstruation |
| | | Vaginal Discharge |

| N | P | GENERAL |
|---|---|---|
| | | Diabetes |
| | | Weight Loss |
| | | Nervousness |
| | | Emotional Problems |

**Date of Last Physical Exam:** _____

**Date of Last Eye Exam:** _____

Do you take any medications? *If you have a list with you, please provide it to the front desk and we will copy it*. If you do not have a list, please write all medications (including non-prescription and over the counter medication and supplements) in the space below.

_____

_____

_____

Do you have any allergies? ( ) Food ( )Environmental ( )Medication

Please list: _____

_____

_____

Have you had any surgeries? If, so, please list the type and date they took place.

_____

_____

_____

_____

**FAMILY HISTORY:** Please put a check in the appropriate boxes.

| | Father | Mother | Sister | Brother | Daughter | Son | Other |
|---|---|---|---|---|---|---|---|
| Cancer | | | | | | | |
| Diabetes | | | | | | | |
| Heart Disease | | | | | | | |
| Heart Failure | | | | | | | |
| High Blood Pressure | | | | | | | |
| Kidney Disease | | | | | | | |
| Thyroid Disease | | | | | | | |
| Arthritis | | | | | | | |
| Obesity | | | | | | | |
| Stroke | | | | | | | |
| Alcoholism | | | | | | | |
| Mental Health Problems | | | | | | | |
| Arteriosclerosis | | | | | | | |
| Digestive Disorder | | | | | | | |
| Spine Disorder | | | | | | | |
| Sinus Problems | | | | | | | |
| Other: | | | | | | | |

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I FURTHER UNDERSTAND THAT HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND ME. IT IS UNDERSTOOD THAT THE FAMILY CHIROPRACTIC OFFICE WILL PREPARE THE NECESSARY DOCTOR'S HEALTH INSURANCE CLAIM FORMS AND REPORTS REQUESTED BY SAID INSURANCE COMPANY OR REPRESENTING LAWYER. THEREFORE, I GIVE THE FAMILY CHIROPRACTIC OFFICE AUTHORIZATION TO RELEASE ANY NECESSARY INFORMATION TO THE CARRIER AND/OR LAWYER. I ALSO UNDERSTAND THAT SHOULD I TERMINATE MY TREATMENT WITHOUT THE DOCTOR'S APPROVAL, ANY FEES FOR PROFESSIONAL SERVICE RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

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

**Parent/Guardian's Signature:** _____

Thank you for your patience with the paperwork process!