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Family Chiropractors
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New Patient Intake Form

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other _____
Race: (For Demographic Reasons) Caucasian African American Asian Other _____
Ethnicity: Hispanic/Latino Non Hispanic/Latino

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Social Security Number: _____-_____-_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children (Name and Age):_____

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Other_____

Insurance Data

Primary Health Insurance Carrier: _____ Secondary Health Insurance Carrier: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____

Primary Care Physician: _____ ******Please present insurance card(s) to be copied ******

Employer Data

Employer: _____

Occupation: _____

Emergency Contact

Contact Name: _____ Relationship to Patient: _____

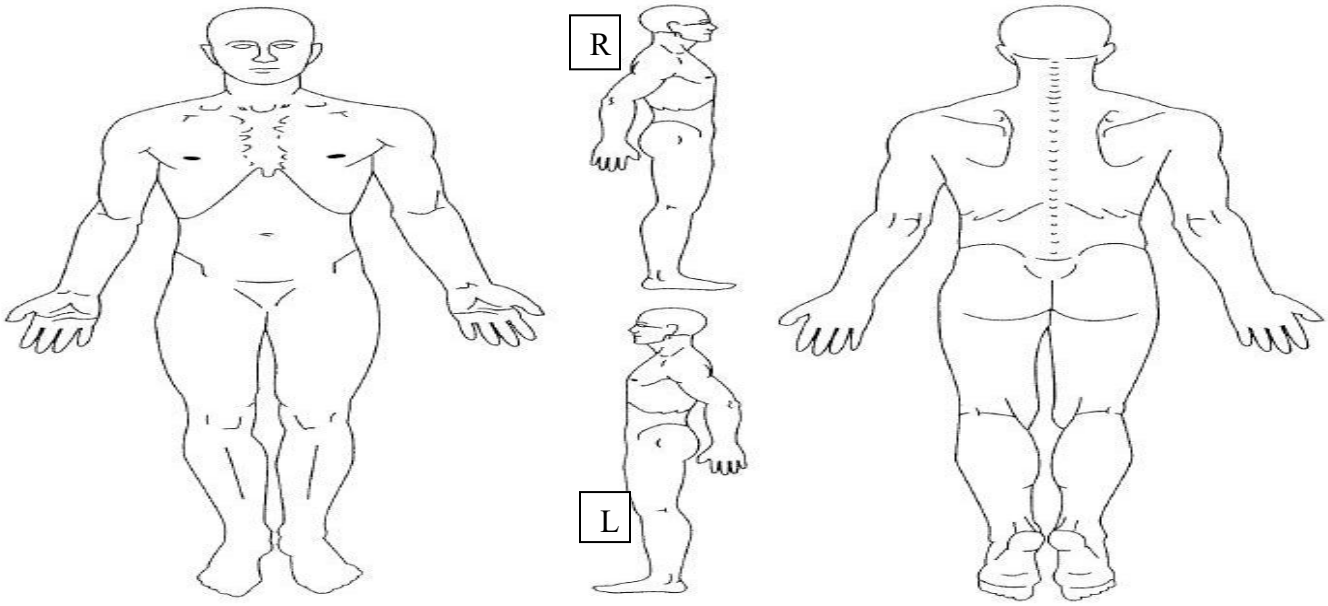
Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Did anyone refer you to our office? If so, please list name(s) _____

Have you ever received chiropractic care? If so, please list where_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Injury (ies): (Circle all that apply to you and provide the DATE of injury)		
Back injury	Head injury (loss of consciousness)	Motor vehicle accident
Broken bones	Head injury (no loss of consciousness)	Soft tissue injury (mild)
Disability (ies)	Industrial accident	Soft tissue injury (moderate)
Fall (severe)	Joint Injury	Soft tissue injury (severe)
Fracture	Laceration (severe)	Other:

Average Pain Intensity: (Please circle)			
Last 24 hours: no pain	0 1 2 3 4 5 6 7 8 9 10	worst pain	
Past week: no pain	0 1 2 3 4 5 6 7 8 9 10	worst pain	
Does anything improve your pain?	Yes No	If Yes, please list:	
When did your symptoms begin?			
How are your symptoms changing?	Getting better	Getting worse	No change
Are You Pregnant? (Circle)	Yes	No	
Are your symptoms a result of**:**	Motor Vehicle Accident	Work related Accident	Other:
How did your symptoms begin?			
How often do you experience your symptoms?			
Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)
Do your current symptoms interfere with your daily activities? (Circle)		Yes	No
What describes the nature of your symptoms?			
Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other _____

What is your primary goal in seeking Chiropractic Care today? (Check all that apply)

- ☐ Acute Care (Symptom relief)
- ☐ Wellness Care (Maximum health benefits)
- ☐ Corrective Care (Correction of problem)

If applicable, please provide a brief description of why you are here today: _____

Medical Conditions: (Circle all that apply to you)			
Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)			
Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)			
Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)			
Caffeine use	Occasional	Often	Never
Drink Alcohol	Occasional	Often	Never
Exercise	Occasional	Often	Never
Drink Water	<64 oz/day	>64 oz/day	Never
Cigarettes	<1 pack/day	>1 pack/day	Never
Sleep	<8 hours/night	>=8 hours/night	Insomnia
Other _____			

Family History: (Circle all that apply)			
Arthritis	Parent	Sibling	Other (Please specify)_____
Cancer	Parent	Sibling	Other (Please specify)_____
Diabetes	Parent	Sibling	Other (Please specify)_____
Heart Disease	Parent	Sibling	Other (Please specify)_____
Hypertension	Parent	Sibling	Other (Please specify)_____
Stroke	Parent	Sibling	Other (Please specify)_____
Thyroid	Parent	Sibling	Other (Please specify)_____
Other _____			

Occupational Activities: (Circle one that best describes your job description)			
Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

Please list all medications you are currently taking and dosages (*you may present a list if necessary and write "see list" below)*

Medication(s)	**Dosage(s)**	**For what condition?**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems – (Please check the appropriate box for each)

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**	Past	Present	No
Jaw Pain				**Eyes**	Past	Present	No				
Irregular Heartbeat								Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary	Past	Present	No	Blurred Vision				Sore Throat			
								Nose bleeds			
Kidney Disease				**Psychiatric**	Past	Present	No	Bleeding Gums			
Burning Urination								Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**	Past	Present	No
Kidney Stones				Stress							
Lower Side Pain								Gall Bladder Problems			
				Endocrine	Past	Present	No	Bowel Problems			
Neurologic	Past	Present	No					Constipation			
				Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**	Past	Present	No				
Pinched Nerves								**Musculoskeletal**	Past	Present	No
Parkinson's				Hepatitis							
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional	Past	Present	No	Bleeding				Muscle Weakness			
				Fever, Chills				Osteoporosis			
Low Energy Level				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
								Neck Pain			
								Low Back Pain			
								Upper Back Pain			

"I hereby authorize the Doctor and whomever he/she may designate as his/her associate to administer chiropractic care as he/she deems necessary"

Patient Name_____**Date**_____