New Practice Member Intake Form

Date:______________________________

First Name: ______________________________

Last Name: ______________________________

Nickname: ______________________________

Address: ______________________________

City: ______________________________

State: __________ Zip Code: ______________

Age: ________ Date of Birth: ______________

Sex: ( ) Male ( ) Female

( ) Single ( ) Married ( ) Divorced ( ) Separated

( ) Widowed

Social Security #: _______- ________- ________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

E-mail:______________________________

Type of work: ______________________

Insurance: ( ) Work Comp ( ) Auto ( ) MA

( ) Medicare ( ) Private: ______________

Who referred you to our office?

____

How were you referred to our office?

( ) Yellow pages ( ) Lecture ( ) Drive by

( ) Coupon ( ) Screening Where? ________

____

( ) Mailing = which one? ____________

( ) Other: ______________________

In case of an emergency, please contact:

Name: ______________________

Phone: ______________________

Relationship: ______________________

Your Health Profile

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives?

____

____

Name/Address/Phone of the last doctor who put you on a health development program?

____

____

Were you able to stay on the program? Y N How long?______________________

What were your results?____

Are you healthier today than you were 5 years ago? Y N Not Sure

If not, why do you think your health declined?

____

____

If so, what did you do to improve your health?

____

____

Will you be healthier 5 years from now than you are today? Y N Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline?

____

____

After making these changes in your life, how do you expect your health to be 5 years from now?

____

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? ____

What was the approximate date of your last visit? ______________________________

What was the duration of your care? ____

What other wellness professionals are currently parts of your health care team?
( ) Massage Therapist ( ) Acupuncturist ( ) Naturopath ( ) Homeopath
( ) Other: ____

Is your current condition the result of a **recent**: ( ) auto accident? ( ) work related injury

What was the date of injury? ____________________

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only):

____

When did you first experience this problem?

____

How did this problem first begin?

____

____

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Please grade the severity of this problem (with 10 being worst):

Now	1	2	3	4	5	6	7	8	9	10
On Average	1	2	3	4	5	6	7	8	9	10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?
_____ Burning _____ Stabbing _____ Aching _____ Sharp
_____ Tingling _____ Numb _____ Other: ______________________

Please describe the location of the pain.

____
____

Does this problem cause pain to travel to any other area? Y N If yes, where?

____
____

Is this problem: In the AM: ( ) worse? ( ) better?
In the PM: ( ) worse? ( ) better?

What seems to aggravate this problem?

____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

____
____

Have you seen any other doctors for this problem? Y N If yes, who?

____
____

What treatment was given?

____

Are you still have problems after the treatment?

____

Secondary Complaint -- if any (List one only):

____

When did you first experience this problem?

____

How did this problem first begin?

____
____

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Please grade the severity of this problem (with 10 being worst):

Now 1 2 3 4 5 6 7 8 9 10

On Average 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?
_____ Burning _____ Stabbing _____ Aching _____ Sharp
_____ Tingling _____ Numb _____ Other: ______________________

Please describe the location of the pain.
____
____

Does this problem cause pain to travel to any other area? Y N If yes, where?
____
____

Is this problem: In the AM: ( ) worse? ( ) better?
In the PM: ( ) worse? ( ) better?

What seems to aggravate this problem?
____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?
____
____

Have you seen any other doctors for this problem? Y N If yes, who?
____
____

What treatment was given?
____

Are you still having problems after the treatment?
____

Lifestyle/Social History

Job Description: ____

Work Schedule: ____

Recreational Activities: ____

Do you smoke? Y N If yes, how much?____

Do you drink alcohol? Y N If yes, how much?____

Do you drink coffee? Y N If yes, how much?____

Do you drink tea? Y N If yes, how much?____

Do you drink water? Y N If yes, how much?____

How regularly are you involved in **Moderate-Intensity** physical activity in which you have some **increased breathing or heart rate?**

( ) Never ( ) 1-2x/Week ( ) 3-4x/Week ( ) 5-7x/Week

What kind of exercise do you do? ____

Daily Fruit Intake: ( ) 1-2 servings ( ) 3-4 Servings ( ) 5 or more servings

Daily Vegetables Intake: ( ) 1-2 servings ( ) 3-4 Servings ( ) 5 or more servings

How many hours of sleep do you get on average? (circle) 4 or less 5-6 7-8 9-10 11 or more

What position do you regularly sleep in? Back Side Stomach

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational _____
Personal _____
Money _____
Computer _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome

When was your last period? ________________________

Are you pregnant? ( ) Yes ( ) No ( ) Not sure

Medical History

Please list any chronic illnesses and/or cause of death and age of any immediate family members (parents or siblings): **Cancer, Heart Disease, Stroke, Diabetes, Debilitating Arthritis**

Relationship	Chronic Illness or Cause of Death	Age of death

Surgeries:

Date	Type	Reason for surgery

Previous injuries or trauma (please give type and date):

____

____

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking

Nutritional Supplements you are currently taking:

Supplement & Dosage	Reason for taking

Allergies:

____

____

Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional) _____		

Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional) _____		

Please Check Below any of the following you have had in the last 12 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:

MUSCULO-SKELETAL

_____Low Back Pain _____Pain Between Shoulders _____Neck Pain _____Arm Pain
_____Joint Pain/Stiffness _____Walking Problems _____Difficult Chewing/Clicking Jaw
_____General Stiffness

GENITO-URINARY
____Painful/Excessive Urination ____Discolored Urine ____Bladder Trouble

CARDIO-VASCULAR- RESPIRATORY
____Chest Pain ____Short Breath ____Blood Pressure Problems
____Irregular Heartbeat ____Heart Problems ____Lung Problems/Congestion
____Varicose Veins ____Ankle Swelling ____Stroke

NERVOUS SYSTEM
____Nervous ____Numbness ____Paralysis ____Dizziness ____Forgetfulness
____Confusion/Depression ____Fainting ____Convulsions ____Stress
____Cold/Tingling Extremities ____Hearing Difficulty

EYES, EARS, NOSE, THROAT
____Vision Problems ____Dental Problems ____Sore Throat
____Ear Aches ____Stuffed Nose

GENERAL
____Fatigue ____Allergies ____Headaches ____Fever

MALE / FEMALE

____Menstrual Irregularity ____Menstrual Cramps ____Vaginal Pain/Infection
____Breast Pain/Lumps ____Prostate/Sexual Dysfunction ____Other: ___________________

GASTRO-INTESTINAL
____Poor/Excessive Appetite ____Excessive Thirst ____Frequent Nausea
____Vomiting ____Diarrhea ____Constipation
____Hemorrhoids ____Liver Problems ____Gall Bladder Problems
____Weight Trouble ____Abdominal Cramps ____Gas/Bloating after Meals
____Heartburn ____Black/Bloody Stools ____Colitis

Please check any of the following illnesses you have ever had:

____Cancer ____Diabetes ____Mental Disorders ____Pneumonia
____Heart Disease ____Rheumatic Fever ____Small Pox ____Pleurisy
____Polio ____Chicken Pox ____Arthritis ____Tuberculosis
____Epilepsy ____Whooping Cough ____Anemia ____Mumps
____Measles ____Thyroid Disorder

Which best describes your reason for consulting our office?

_____ I have a specific concern and require help with this concern.

_____ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

_____ I want to be healthier five years from now than I am today.