

Back & Neck Pain Relief Center

1710 West Third Street Bloomington, IN 47404

Patient Intake Form

First Name: _____ Mid Name: _____

Sex: Male Female

Last Name: _____

Email Address: _____

Home Phone: _____ Cell: _____

Preferred Appt Reminder Method:

Social Security #: _____ DOB: ____/____/____

Email Text Cell Phone Home Phone

Current Address: _____

Employer: _____

Apt #: _____ City: _____

Type of Work: _____

State/Province: _____ Postal/Zip Code: _____

Emergency Contact (Name & Number): _____

Permanent Mailing Address: _____

_____ Apt #: _____ City: _____

Relationship: _____

State/Province: _____ Postal/Zip Code: _____

Referred to Office By: _____

Are your present problems due to an injury? Yes No Enter the date of the injury: _____

Was the injury? Job Related Auto Accident Personal Injury Other: _____

Has the accident been reported? Yes No If so, to whom? To Employer Auto Carrier Other: _____

Briefly describe the accident, injury or illness: _____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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List any tests, studies or medications received for this condition:

Tests/Studies: _____

Medications: _____

Where you admitted to the hospital due to this condition: Yes No

If yes, what hospital? _____ Transported by? Ambulance Police Other: _____

Date Admitted: _____ Date Released: _____ Length of Stay: _____

List the hospital procedures received: _____

List symptoms you are experiencing today:

Choose the severity level associated with each symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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Do you have any current work restrictions due to this condition?

Off work: Yes No Previously From: _____ To: _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

What type of work do you do? _____

Do you suffer from any condition other than that for which you are now consulting us? Yes No

List any past conditions you may have had: _____

HABITS

Current Every Day Smoker Current Some Day Smoker

Former Smoker Never Smoker

Drinking Alcohol: (Cups/day): _____ Coffee Cups/Day: _____

Soft Drink Bottles or Cans/Day: _____ Water Cups/Day: _____

EXERCISE

None

Moderate

Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you taking any medication (prescription or over-the-counter)? Yes No

If Yes, please indicate the following:

Medication: _____

Route: Oral Intravenous Other: _____

Frequency: _____

Began Use: _____

Discontinued Use: _____

Medication: _____

Route: Oral Intravenous Other: _____

Frequency: _____

Began Use: _____

Discontinued Use: _____

Medication: _____

Route: Oral Intravenous Other: _____

Frequency: _____

Began Use: _____

Discontinued Use: _____

Medication: _____

Route: Oral Intravenous Other: _____

Frequency: _____

Began Use: _____

Discontinued Use: _____

Have you taken any medications in the past? Yes No If yes, which ones?: _____

Do you have allergies to medication? Yes No

If Yes, please indicate the following:

Allergy: _____	Allergy: _____
Reaction: _____	Reaction: _____
Start Date: _____	Start Date: _____
End Date: _____	End Date: _____

Have you ever had any surgeries? Yes No (If yes, please enter the approximate date of surgery.)

DATE	DATE	DATE
_____ Back Operation	_____ Hernia	_____ Gall Bladder
_____ Female Organs	_____ Thyroid	_____ Stomach

Other: _____

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR	NOSE/THROAT	RESPIRATORY
<input type="checkbox"/> Allergy(What) _____	<input type="checkbox"/> Belching or Gas		<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Colon Trouble		<input type="checkbox"/> Deafness	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chills (Constant)	<input type="checkbox"/> Constipation		<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gall Bladder Trouble		<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> Fainting	<input type="checkbox"/> Hemorrhoids (piles)		<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Jaundice		<input type="checkbox"/> Frequent Colds	GENITO-URINARY
<input type="checkbox"/> Headache	<input type="checkbox"/> Liver Trouble		<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Nausea		<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Stomach Pain		<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Vomiting		<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Vomiting Blood		<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Numbness or Pain in arms/legs/hands	<input type="checkbox"/> Heart Burn		<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bloody Stools		<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Acid Reflux		<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Prostate Trouble
	<input type="checkbox"/> Irritable Bowel		<input type="checkbox"/> Tonsillitis	

MUSCLES & JOINTS

- Backache
- Foot Trouble
- Hernia
- Pain Between
Shoulders
- Painful Tail Bone
- Stiff Neck
- Spinal Curvature
- Swollen Joints
- Tremors

CARDIO-VASCULAR

- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- Heart Trouble
- Poor Circulation
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

SKIN OR ALLERGIES

- Bruising Easily
- Dryness
- Eczema
- Hives or Allergy
- Itching
- Sensitive Skin
- Skin Eruptions

FOR FEMALES ONLY

- Cramps
- Hot Flashes
- Irregular Cycle
- Painful Periods
- Vaginal Discharge
- Pregnant Now?
_____ Last Pap Date
_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | | | |
|---------------------------------------|--------------------------------------|--|------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV Positive |

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

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

Please list contact information of individual(s) you authorize to discuss and/or may release medical and/or financial information to:

Name of Individual: _____

Phone Number: _____

Address: _____

Insurance Info (If other than the patient):

Primary Insurance _____ **Employer** _____

Subscribers Name _____ **Date Of Birth** _____ **Relationship** _____

Address if different than Patient's or Guarantor's _____