A WAY OF WELLNESS CHIROPRACTIC

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 <u>immediately after the injury</u>: Choose the severity level associated with each symptom

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

______________________ ☐(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 <u>today</u>:

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 <u>now</u> consulting us? ❑Yes ❑No

____

List any <u>past</u> 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	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

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: ______________________

Medication: ______________________
Route: ☐Oral ☐Intravenous ☐Other:________
Frequency: ______________________
Began Use: ______________________

Discontinued 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

- ❑ Allergy(What) _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination

❑ Wheezing ❑ Irritable Bowel ❑ Tonsillitis ❑ Prostate Trouble

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 <u>HAVE</u> OR <u>HAVE YOU HAD</u> ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

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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: _____

<u>Insurance Info (If other than the patient):</u>

Primary Insurance _____ **Employer** _____

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

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