

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 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 been told you have High Cholesterol or Triglycerides? YES / NO

Have you ever been diagnosed with High Blood Pressure? YES / NO

Have you been Diagnosed as Diabetic? YES / NO

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? YES / NO

How many days a week do you skip a meal? (3/meals/day) _____

How many "fast food", "refined food", or "pre-prepared" meals to you eat per week?

(0) (1-3) (4-6) (7+)

How many servings of fruit do you eat per day?

(0-1) (2-3) (4-5)

How many servings of vegetables do you eat per day?

(0-1) (2-3) (4-5)

Do you regularly drink 1 or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you eat per day? (Candy, Cookies, Cake, etc)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins you take regularly:

(Staff can photocopy a list if you have one)

Supplement Name/Type	Frequency	Brand or Where Purchased
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 circle each current or past symptom listed you are experiencing.

CONSTITUTIONAL

Chills Weight Gain
Drowsiness Weight Loss
Fainting
Fatigue
Fever
Night Sweats
Weakness

EYES

Blindness Field Cuts
Blurred Vision Glaucoma
Cataracts Sensitivity to Light
Change in vision Tearing
Double Vision Wears Glasses
Dry eyes
Eye Pain

CARDIOVASCULAR

Angina High Blood Pressure
Chest Pain Low Blood Pressure
Claudication Orthopnea
Heart Murmur Palpitations
Heart Problems Shortness of Breath
Swelling of Legs Varicose Veins

RESPIRATORY

Asthma
Bronchitis
Dry Cough
Productive Cough
Coughing up Blood
Difficulty Breathing
Difficulty Sleeping
Hemoptysis
Pneumonia
Sputum Production
Wheezing

MUSCULOSKELETAL

Arthritis Muscle Twitching
Neck Pain Muscle Weakness
Decreased Motion Swelling
Gout
Injuries
Joint Pain
Joint Stiffness
Locking Joints
Back Pain
Muscle Cramps
Muscle Pain

INTEGUMENTARY

Breast Lumps/Pain
Change in Nail Texture
Change in Skin Color
Eczema
Hair Growth
Hair Loss
History of Skin Disorders
Hives
Itching
Paresthesia
Rash
Skin Lesions

GASTROINTESTINAL

Abdominal Pain
Belching
Black, Tarry Stools
Constipation
Diarrhea
Heartburn
Hemorrhoids
Indigestion
Jaundice
Nausea

EAR/NOSE/MOUTH/THROAT

Bad Breath
Dentures
Deviated Septum
Difficulty Swallowing
Discharge
Dry Mouth
Ear Drainage
Ear Pain
Frequent Sore Throats
Head Injury
Hearing Loss
Ringing in Ears

Rectal Bleeding
Abnormal Stool Caliber
Abnormal Stool Color
Vomiting
Vomiting Blood

Hoarseness
Loss of Smell
Loss of Taste
Congestion
Nose Bleeds
Postnasal Drip
Sinus Infections
Runny Nose
Snoring
Sore Throat
TMJ
Ulcers

PSYCHIATRIC

Agitation
Anxiety
Appetite Changes
Behavioral Changes
Bipolar Disorder
Substance Abuse

Confusion
Convulsions
Depression
Insomnia
Memory Loss

GENITOURINARY

Birth Control
Burning Urination
Cramps
Erectile Dysfunction
Hesitancy/Dribbling
Hormone Therapy
Irregular Menstruation

Lack of Bladder Control
Prostate Problems
Urine Retention
Vaginal Bleeding
Vaginal Discharge

NEUROLOGICAL

Change in Concentration
Change in Memory
Dizziness
Headache
Imbalance
Loss of Consciousness
Loss of Memory
Numbness
Seizures
Sleep Disturbance
Slurred Speech
Stress

Strokes
Tremors

ENDOCRINE

Cold-or-Heat Intolerance
Diabetes
Excessive Hunger/Thirst
Goiter
Hair Loss-or-Unusual Growth
Voice Changes

HEMATOLOGIC / LYMPHATIC

Anemia
Bleeding
Blood Clotting
Blood Transfusions
Bruise Easily
Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC

History of Anaphylaxis

Itchy Eyes

Sneezing

Specific Food Intolerance

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. I also take responsibly for the bill of any services rendered, including that of which health insurance does not cover. 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 _____