A Way of Wellness Chiropractic

Patient Intake Form

First Name: _____ MI: _____ Sex: Male Female

Last Name: _____ DOB: _____

Social Security# _____ Email address: _____

Home Phone: _____ Cell Phone: _____

Preferred Appt Reminder Method: Email Text Cell Phone Home Phone

Current Address: _____ Employer: _____

Apt #: _____ City: _____ Type of Work: _____

State: _____ Zip Code: _____ Emergency Contact (Name and Number)

Permanent Mailing Address: _____ _____

_____ Apt #: _____ City: _____ _____

State: _____ Zip Code: _____ Who referred you? _____

Are your present problems due to an injury? Yes/No Date of Injury: _____

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

Has the accident been reported? Yes/No

If so, to whom? Employer Auto Carrier Other: _____

Briefly Describe the accident:

_____

_____

_____

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List any Symptoms Experienced **immediately after the injury and rate your pain on a scale of 1-10:**

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

List any test, studies or medications received for this injury:

Test/studies: _____

Medications: _____

Were you admitted to the hospital Yes / No

If so, where, and how long? _____

Were you transported by Ambulance Police Other: _____

List symptoms you are experiencing **today and rate them on a scale of 1-10**:

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

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

Off work: Yes/No/ Previously From: _____ to _____

Light duty: Yes/No/Previously From: _____to _____

What type of work do you do: _____

Do you suffer from any other condition than what you are consulting us for now?

_____

_____

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Other Doctors you see;

Primary Care Physician:

Name: _____

Address: _____

_____

Phone Number: _____

Other Physician:

Name: _____

Address:_____

_____

Phone Number: _____

Other Physician:

Name: _____

Address:_____

_____

Phone Number: _____

Medications:

1._____

Dose/frequency: _____

2._____

Dose/frequency: _____

3._____

Dose/frequency: _____

Do you have an allergies to medications?

Yes/No

What kind of reaction? _____

Habits:

Are you a smoker? Yes/No/Former

Do you drink? Yes/No/Former Alcohol: (cups/day) _____

Coffee: (cups/day) _____ Soft Drinks: (cups/day)_____ Water: (cups/day) _____

Exercise: None Moderate Daily

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History:

High Cholesterol/Triglycerides Yes/No

High Blood Pressure? Yes/No

Diabetes? Yes/No

Pre-Diabetic or Metabolic Syndrome? Yes/No

Family History:

Mother: Diabetes Cancer Back Pain

Father: Diabetes Cancer Back Pain

Siblings(s): Diabetes Cancer Back Pain

How many days a week do you skip a meal? _____

How many "fast food" or "refined food" meals a week? _____

How many servings of fruit do you eat per day? _____

How many servings of vegetables do you eat per day?_____

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

Juice Soda Diet Soda Milk Alcohol Coffee

How many servings of refined sugar do you eat per day? (Candy, cookies, cakes etc.) :_____

Please list all nutritional supplements/vitamins you take regularly:

Name	Frequency	Brand
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any surgeries? (Please list with approx. dates)

_____

_____

Have you had any x-rays taken? (Please list with approx. dates)

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Operations and Procedures (circle which ones apply)

Constitutional	**Eyes**	**Cardiovascular**	**Respiratory**
Chills	Blindness	Angina	Asthma
Drowsiness	Blurred Vision	High Blood Pressure	Bronchitis
Fainting	Cataracts	Low Blood Pressure	Dry Cough
Fever	Vision Changes	Chest Pain	Trouble Breathing
Weakness	Double Vision	Heart Murmur	Trouble Sleeping
Weight Gain	Eye Pain	Heart Problems	Coughing Blood
Weight Loss	Field Cuts	Swelling in Legs	Hemoptysis
Fatigue	Glaucoma	Orthopnea	Pneumonia
Night Sweats	Light Sensitivity	Palpitations	Sputum Production
	Glasses	Shortness of Breath	Wheezing
	Dry Eyes	Varicose Veins	

Musculoskeletal	**Integumentary**	**Endocrine**
Arthritis	Breast Lumps/Pain	Diabetes
Neck Pain	Change in nails	Excessive Hunger/Thirst
Decreased Motion	Change in skin	Goiter
Gout	Eczema	Voice Changes
Joint Pain	Hair Loss/Growth	Cold/Heat Intolerance
Muscle Cramps/Pain	Hives/Rashes	Unusual Hair Growth
Muscle Twitching/Weakness	Paresthesia	
Swelling	Psoriasis/ itching	

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Gastrointestinal

Abdominal Pain
Belching
Rectal Bleeding
Black, Tarry Stools
Constipation
Diarrhea
Heartburn
Hemorrhoids
Indigestion
Jaundice
Nausea
Rectal Bleeding
Abnormal Stool caliber
Abnormal Stool Color
Vomiting
Vomiting Blood

Genitourinary

Birth Control
Pain with Urination
Cramps
Erectile Disfunction
Hormone Therapy
Irregular Menstrual
Lack of Bladder Control
Prostate Problems
Urine Retention
Vaginal Bleeding
Vaginal Discharge

Ear/Nose/Mouth/Throat

Bad Breath
Dentures
Dry Mouth
Drainage
Nose Bleeds
Loss of Smell/Taste
Congestion
Runny nose
TMJ
Ear Pain
Ringing in Ears
Ulcers
Sore Throat
Hearing Loss
Hoarseness
Snoring
Difficulty Swallowing

Hematologic/ Lymphatic

Anemia
Bleeding
Blood Clotting
Blood Transfusions
Easily Bruised
Lymph Node Swelling

Neurological

Memory Changes
Dizziness
Headache
Imbalance
Numbness
Stress
Slurred Speech
Strokes
Tremors

Psychiatric

Agitation
Anxiety
Bipolar
Substance Abuse
Confusion
Insomnia
Depression
Convulsions
Behavioral Changes

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Do you HAVE or HAVE YOU HAD any of the following diseases?

Please circle all that apply

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

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 my authority for these procedures to be performed. I also take responsibility for the bill of any services rendered, including that of which health insurance does not cover. It is understood and agreed that imaging is for examination only and the images will remain property of this office, being on file where they may be viewed.

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

Patient name Printed: _____

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

Name of Individual: _____ Relationship:_____

Phone Number: _____

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