New Patient Intake Form

Care Card #: _____ Today's Date: __/__/____

Patient Name: _____ Birthday: __/__/____ Female ☐ Male ☐

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alt. Phone: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Number: _____ Relationship: _____

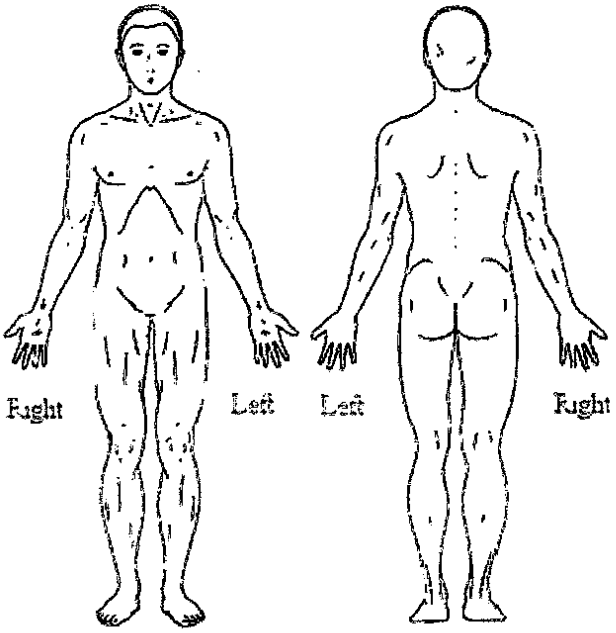
Doctor's Name: _____ Number: _____
Address: _____ Last Visit: _____

REASON FOR VISIT: _____

When did your symptoms begin? _____
Is your condition getting progressively worse? Yes ☐ No, getting better ☐ About the Same ☐
Have you had this problem before? Yes ☐ No ☐ If so, When? _____

Please Circle the Intensity of your Pain. (0 = no pain, 10 = worst pain ever)

0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10



Using the symbols below, please mark the location and character of your pain.

Numbness: = = =

Dull Ache: OOO

Sharp/Stabbing: +++

Burning: XXX

Pins, Needles, Tingle: ///

Is your complaint due to an accident? No ☐ Yes ☐ Date of Accident : _____ Type of Accident:
Auto ☐ Work-Related ☐ Have you reported this accident? Yes ☐ No ☐

Have you seen another practitioner for this complaint? No ☐ Yes ☐ If so, Who? _____
What was the treatment? _____ What was the outcome? _____

Chief Chiropractic & Sports Injury Clinic

Past Health History

Have you ever had previous Chiropractic Care? No ☐ Yes ☐ If so, When? _____
Have you had any falls or traumas (Car Accidents)? No ☐ Yes ☐ _____
Have you had any fractures/surgeries? No ☐ Yes ☐ _____
Have you ever been hospitalized? No ☐ Yes ☐ _____
Are you a smoker? No ☐ Yes ☐ _____
Are you currently taking any medications? No ☐ Yes ☐
List of Medications: _____

Have you ever been diagnosed with any of the following diseases? Please **Circle**

Heart Disease	Tuberculosis	Cancer	Measles
Heart Attack	Pleurisy	Thyroid Disease	Mumps
Atherosclerosis	Asthma	Arthritis	Chicken Pox
Stroke	Anemia	Rheumatic Fever	Epilepsy
Pneumonia	Diabetes	Polio	Influenza

Circle any of the following symptoms that are currently affecting you.
Check any that have affected you in the past.

General Symptoms
- Fatigue
- Loss of Sleep
- Headache
- Fever/Chills
- Allergies
- Night Sweats

Musculoskeletal Complaints
- Low Back Pain
- Midback Pain
- Neck Pain
- Neck Stiffness
- Shoulder Pain
- Elbow Pain
- Wrist Pain
- Hand/Finger Pain
- Hip Pain
- Thigh Pain
- Knee Pain
- Calf Pain
- Ankle Pain
- Foot/Arch Pain
- Jaw Pain/Clicking
- Joint Stiffness
- Swollen Joints

Skin Complaints
- Bruise Easily
- Bleed Easily
- Dryness
- Sensitive Skin
- Rashes/Eczema

Nervous System
- Numbness/Tingling
- Weakness/Paralysis
- Dizziness
- Light-Headedness
- Depression
- Convulsions
- Stress/Nervous

Cardiovascular Complaints
- Chest Pain
- Chest Pressure
- High/Low Blood Pressure
- Varicose Veins
- Swollen or Cold Extremities
- Irregular Heartbeat

Respiratory Complaints
- Chest Pain
- Short of Breath
- Wheezing
- Chronic Cough
- Spitting up Blood

EENT Complaints
- Blurry Vision
- Light Sensitivity
- Ear Aches
- Hearing Loss
- Ringing in Ears
- Sinus Congestion
- Sore Throat
- Dental Problems
- Enlarged Glands
- Poor Balance

Gastrointestinal Complaints
- Abdominal Pain
- ↑ Appetite
- ↓ Appetite
- Weight Loss
- Weight Gain
- Excessive Thirst
- Difficult Swallow
- Heartburn/ Reflux
- Nausea
- Vomiting (Blood)
- Gas/Bloating
- Abd. Cramps
- Diarrhea
- Constipation
- Blood in Stool
- Colon Problems
- Liver Problems
- Gall Bladder Problems

Genito-Urinary Complaints
- Painful Urination
- Frequent Urination
- Incontinence
- Discolored Urine

For Women Only
- Painful/Irregular Menstruation
- Cramps/Backaches
- Menopause
- Hot Flashes

Are you Pregnant?
No ☐ Yes ☐

Are you taking Birth Control Pills?
No ☐ Yes ☐
How long? _____

Are you on HRT?
No ☐ Yes ☐
How long? _____