

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: _____

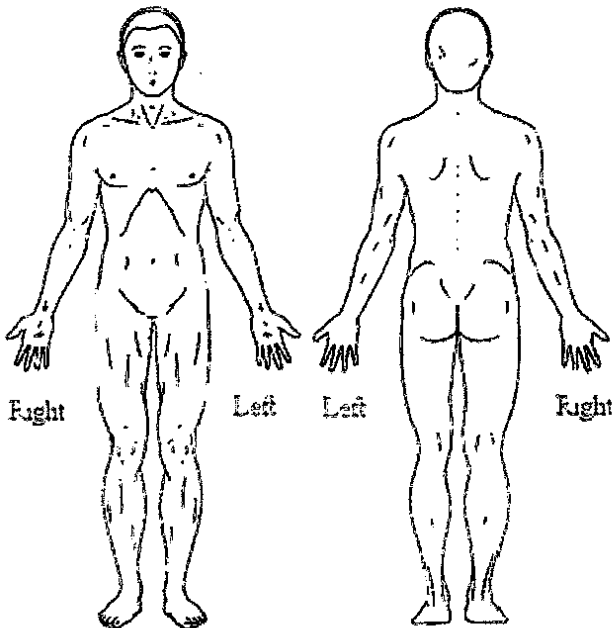
REASON FOR VISIT: _____

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? _____

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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

Nervous System

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

Sinus Congestion

Sore Throat
Dental Problems
Enlarged Glands
Poor Balance

For Women Only

Painful/Irregular
Menstruation
Cramps/Backaches
Menopause
Hot Flashes

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

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

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

Are you Pregnant?
No Yes

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

Are you on HRT?
No Yes
How long? _____

Skin Complaints

Bruise Easily
Bleed Easily
Dryness
Sensitive Skin
Rashes/Eczema

EENT Complaints

Blurry Vision
Light Sensitivity
Ear Aches
Hearing Loss
Ringing in Ears

Genito-Urinary Complaints

Painful Urination
Frequent Urination
Incontinence
Discolored Urine