Got Your Back Lifestyle Chiropractic

# NEW PATIENT INTAKE FORM

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone (home) _____ (cell) _____ (work) _____

Email address _____

Birthdate _____ Age _____

Occupation _____ Employer _____

Children's names and ages _____

_____

Do you have any pets? ❑ No ❑ Yes If yes, please tell us what kind(s): _____

_____

Emergency Contact: Name _____

Relationship _____ Phone _____

Favorite hobbies or interests _____

## What Brings You Here?

Have you ever had chiropractic care before? ❑ No ❑ Yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ❑ No ❑ Yes

How did you find out about our office? _____

Is this appointment related to ❑ work ❑ sports ❑ auto
❑ personal injury ❑ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ❑ No ❑ Yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❑ No ❑ Yes If yes, what month? _____

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## Health History

Do you have, or have you had, any of the following (please check all that apply).

- ❑ pneumonia
- ❑ mumps
- ❑ influenza
- ❑ rheumatic fever
- ❑ smallpox
- ❑ pleurisy
- ❑ polio
- ❑ chicken pox
- ❑ thyroid disease
- ❑ diabetes
- ❑ epilepsy
- ❑ cancer
- ❑ depression
- ❑ whooping cough
- ❑ anemia
- ❑ eczema
- ❑ measles
- ❑ arthritis
- ❑ heart disease
- ❑ rashes

If you have ever been diagnosed with another disease or condition, please describe_____

_____

Do you use

- ❑ coffee
- ❑ tea
- ❑ artificial sweeteners
- ❑ sugar
- ❑ alcohol
- ❑ cigarettes
- ❑ recreational drugs

Have you ever suffered from the following any of the following (please check all that apply).

- ❑ neck pain
- ❑ low back pain
- ❑ headache
- ❑ migraines
- ❑ arm pain/tingling
- ❑ shoulder pain
- ❑ hand pain/tingling
- ❑ leg pain/tingling
- ❑ jaw pain
- ❑ chest pain
- ❑ lung problems
- ❑ heart problems
- ❑ abnormal blood pressure
- ❑ irregular heartbeat
- ❑ ankle swelling
- ❑ cold extremities
- ❑ blurred vision
- ❑ vision problems
- ❑ difficulty breathing
- ❑ stuffy nose
- ❑ allergies
- ❑ fainting
- ❑ weight loss
- ❑ poor appetite
- ❑ excessive appetite
- ❑ nervousness
- ❑ confusion
- ❑ depression
- ❑ dental problems
- ❑ excessive thirst
- ❑ frequent nausea
- ❑ vomiting
- ❑ prostate problem
- ❑ breast pain/lump
- ❑ cramps
- ❑ painful urination
- ❑ bladder trouble
- ❑ excessive urination
- ❑ discolored urine
- ❑ gas/bloating after meals
- ❑ heartburn
- ❑ colitis
- ❑ irritable bowel
- ❑ black or bloody stools
- ❑ constipation
- ❑ hemorrhoids
- ❑ liver problems
- ❑ stroke
- ❑ paralysis
- ❑ tingling
- ❑ numbness
- ❑ fatigue
- ❑ dizziness
- ❑ loss of sleep
- ❑ difficulty hearing
- ❑ ear pain

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check all that apply).

- ❑ falls/accidents
- ❑ sports injuries
- ❑ spinal tap
- ❑ use(d) cane or walker
- ❑ knocked unconscious
- ❑ head injuries
- ❑ broken bones
- ❑ surgery
- ❑ extensive dental work
- ❑ fights
- ❑ dislocations
- ❑ traction
- ❑ dental appliances

If yes to any of the above, please describe _____

_____

_____

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## Current Health

What are your most pressing health concerns? _____

_____

_____

_____

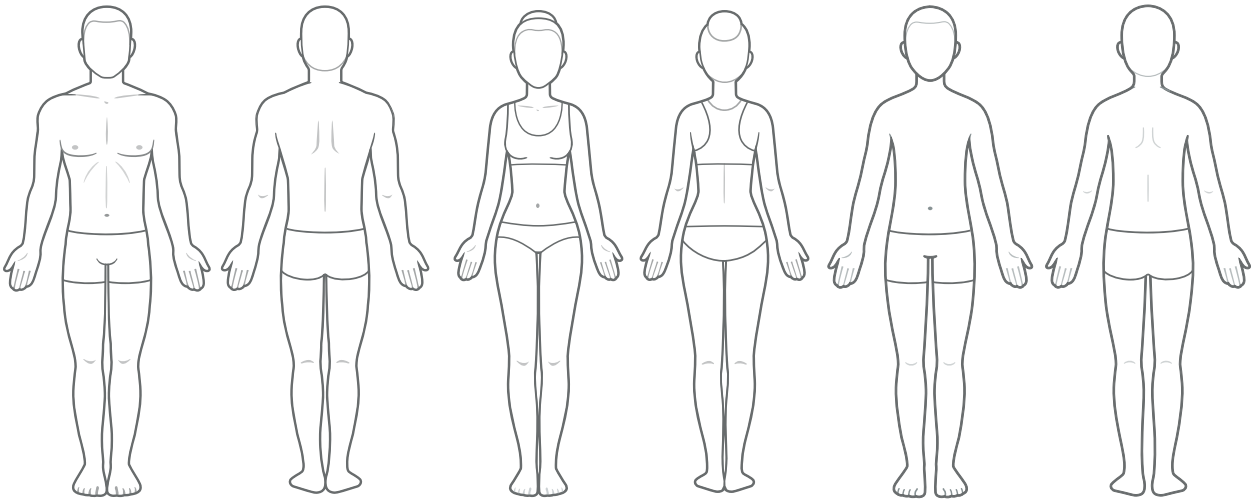
_____

For how long? _____

_____

Is it
- ❑ getting worse
- ❑ improving
- ❑ intermittent
- ❑ constant
- ❑ can't say

Where is the problem? Please use the illustrations and lines below to explain.



Front _____

_____

_____

_____

_____

_____

Back _____

_____

_____

_____

_____

_____

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Do you have ❑ pain ❑ numbness ❑ tingling ❑ aches

Is your pain ❑ sharp ❑ dull ❑ throbbing ❑ constant ❑ intermittent

Are your symptoms affected by ❑ sitting ❑ standing ❑ walking ❑ bending ❑ lying down ❑ weather

Please explain _____

_____

Do you feel ❑ cramps ❑ burning ❑ other ❑ swelling ❑ stiffness _____

Do your symptoms interfere with ❑ work ❑ sleep ❑ other ❑ day-to-day activities ❑ play _____

Please explain _____

_____

On a scale of 1-10 (1 least, 10 most), please rate the severity of your symptoms.

1 2 3 4 5 6 7 8 9 10

## What Do You Know About Chiropractic?

In your own words, what do Chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ❑ No ❑ Yes

If yes, please describe _____

_____

_____

Do any friends or relative see Chiropractors? ❑ No ❑ Yes

If yes, do they use chiropractic for ❑ health maintenance/optimization ❑ health problems ❑ both

Are you seeking chiropractic for ❑ health maintenance/optimization ❑ health problems ❑ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

If yes, please tell us_____

_____

_____

_____

Notes_____

_____

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