

INITIAL INTAKE FORM

CASE NUMBER\_\_\_\_\_

DATE\_\_\_\_\_

TYPE OF CASE.....Health Insurance\_\_\_ HMO\_\_\_ PPO\_\_\_ Cash \_\_\_\_\_  
Medicare\_\_\_ Personal Injury\_\_\_ Medicaid\_\_\_ Worker's Compensation\_\_\_

DATE FIRST CONSULTED WITH ANY DOCTOR FOR THIS CONDITION\_\_\_\_\_

FIRST NAME\_\_\_\_\_INITIAL\_\_\_\_\_LAST NAME\_\_\_\_\_

HOME ADDRESS\_\_\_\_\_

CITY, STATE, ZIP CODE\_\_\_\_\_

HOME PHONE# ( )\_\_\_\_\_AGE\_\_\_\_\_ BIRTH DATE\_\_\_/\_\_\_/\_\_\_

CELL PHONE # ( )\_\_\_\_\_ E-MAIL \_\_\_\_\_

SEX: MALE\_\_\_ FEMALE\_\_\_ SOCIAL SECURITY NUMBER\_\_\_\_\_

MARITAL STATUS: MARRIED\_\_\_ SINGLE\_\_\_ WIDOW OR WIDOWER\_\_\_

OCCUPATION\_\_\_\_\_

PART TIME\_\_\_\_\_ FULL TIME\_\_\_\_\_ RETIRED\_\_\_\_\_

EMPLOYER (patient)\_\_\_\_\_

WORK STREET ADDRESS\_\_\_\_\_

WORK CITY, STATE, ZIP\_\_\_\_\_

WORK PHONE # ( )\_\_\_\_\_

NAME OF SPOUSE\_\_\_\_\_

OCCUPATION (spouse)\_\_\_\_\_PT\_\_\_\_\_FT\_\_\_\_\_RETIRED\_\_\_\_\_

EMPLOYER (spouse)\_\_\_\_\_

SPOUSE' S WORK STREET ADDRESS\_\_\_\_\_

CITY, STATE, ZIP\_\_\_\_\_

WORK PHONE # ( )\_\_\_\_\_

DATE OF INITIAL VISIT HERE AT THIS OFFICE\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS COMPLAINT?\_\_\_\_\_

NEXT OF KIN/FRIEND\_\_\_\_\_PHONE#( )\_\_\_\_\_

**HISTORY.**

SINGLE\_\_\_ MARRIED\_\_\_ SEPARATED\_\_\_ WIDOW\_\_\_ WIDOWER\_\_\_  
SMOKE - YES\_\_\_ NO\_\_\_ HOW MUCH?\_\_\_ HOW LONG?\_\_\_  
ALCOHOL CONSUMPTION - YES\_\_\_ NO\_\_\_ QUANTITY\_\_\_  
CHILDREN - YES\_\_\_ NO\_\_\_ HOW MANY?\_\_\_ AGES\_\_\_ LIVING AT HOME?\_\_\_  
CURRENTLY WORKING? YES\_\_\_ NO\_\_\_ RETIRED\_\_\_ IF SO DOING WHAT?\_\_\_  
JOB DESCRIPTION\_\_\_\_\_

**PREVIOUS MEDICAL HISTORY.**

OPERATIONS - TYPE & YEAR\_\_\_\_\_

PREVIOUS CHIROPRACTIC CARE -- WHEN AND WHOM\_\_\_\_\_

CAR ACCIDENTS -- YEAR & INJURIES\_\_\_\_\_

OTHER ACCIDENTS - YEAR & INJURIES\_\_\_\_\_

ANY ABUSE\_\_\_\_\_

LIST SIGNIFICANT MEDICAL PROBLEMS BOTH CURRENT AND PAST\_\_\_\_\_

ANY IDENTIFYING MARKS, SCARS, OR TATOOS -- WHERE, AND DESCRIBE\_\_\_\_\_

LIST MEDICATIONS YOU ARE CURRENTLY TAKING PRESCRIBED BY MEDICAL DOCTOR AND PURPOSE\_\_\_\_\_

LIST MEDICATIONS YOU ARE CURRENTLY TAKING THAT YOU BUY IN A DRUG STORE\_\_\_\_\_

ALLERGIES.\_\_\_\_\_

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN? NO\_\_\_ YES\_\_\_ WHOM?\_\_\_\_\_

**FEMALE HISTORY.**

NUMBER OF PREGNANCIES\_\_\_ DATE OF LAST PERIOD\_\_\_\_\_  
POSSIBILITY OF YOU BEING PREGNANT? YES\_\_\_ NO\_\_\_ MAYBE\_\_\_  
ARE YOU POST-MENOPAUSAL? YES\_\_\_ NO\_\_\_ HAVE YOU HAD A TUBAL LIGATION? YES\_\_\_ NO\_\_\_  
HYSTERECTOMY? YES\_\_\_ NO\_\_\_ ARE YOU CURRENTLY USING BIRTH CONTROL? YES\_\_\_ NO\_\_\_

**HAVE YOU HAD ANY OF THE FOLLOWING?**

\_\_\_ALCOHOL DEPENDENCY \_\_\_HEPATITIS \_\_\_HIV TESTING \_\_\_BLOOD THINNING  
\_\_\_HIGH BLOOD PRESSURE \_\_\_BLEEDING TENDENCY \_\_\_KIDNEY DISORDER MEDICATION  
\_\_\_BROKEN BONES \_\_\_LUNG CONDITION \_\_\_TUBERCULOSIS \_\_\_CIRCULATION  
\_\_\_STROKE \_\_\_ULCER DISEASE \_\_\_DRUG DEPENDENCY PROBLEMS  
\_\_\_DIABETES \_\_\_CANCER OTHER\_\_\_\_\_  
\_\_\_GALLBLADDER DISEASE \_\_\_EPILEPSY \_\_\_\_\_  
\_\_\_HEART ATTACK/DISEASE \_\_\_ARTHRITIS \_\_\_\_\_

WHAT IS YOUR MAJOR COMPLAINT?\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PROBLEM?\_\_\_\_\_

IS THIS CONDITION THE RESULT OF AN ACCIDENT? \_\_\_YES \_\_\_NO; EXPLAIN\_\_\_\_\_

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ FILE  
NO. \_\_\_\_\_

**Please Check (✓) All of Your Present Symptoms:**

**HEADACHES.**

- Base of Skull
- Top of Head
- Behind Eyes
- Entire Head
- Temples:                   R     L
- Sinus
- Allergy
- Forehead
- Migraine

Tension Between Shoulders

**HANDS.**

- Pain:                               R     L
- Cold Hands
- Loss of Grip Strength

**FINGERS.**

- Pain:                               R     L
- Which Fingers? \_\_\_\_\_

- Swelling
- Arthritis
- Sore Joints
- Fingers Go to Sleep
- Sensation of Pins and Needles

**NUMBNESS.**

- Arms:                               R     L
  - Shoulder to Elbow
  - Elbow to Hand
- Hands:                               R     L
- Fingers:                            R     L

Which Fingers?  
Thumb   Index   Bird   Ring

Little

**ARMS.**

- Pain in Upper Arm:               R     L
- Pain in Lower Arm:               R     L
- Aggravated by Movement
- Tennis Elbow                       R     L

**MID-BACK.**

- Pain Between Shoulder Blades
- Pain from Front to Back
- Pain in Shoulder Blades: R     L

**CHEST.**

- Pain
- Shortness of Breath
- Pain in Rib Cage
- Breast Pain

**HEAD.**

- Dizzy
- Loss of Balance
- Light-Headedness
- Blurred Vision
- Double Vision
- Loss of Vision
- Change in Vision
- Loss of Taste
- Loss of Smell
- Loss of Hearing

**NECK.**

- Neck Pain:
  - R                    L
  - Center            Base
- Pain with Movement:
  - Forward
  - Backward
  - Turning:               R     L
  - Bending:               R     L
- Muscle Spasms
- Grinding Sounds
- Popping Sounds

**SHOULDERS.**

- Pain in Joint:                   R     L
- Bursitis:                         R     L
- Can't Raise Arm
  - Above Head:           R     L
  - Above Shoulders:       R
- Popping Sounds

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ FILE # \_\_\_\_\_

**LOWER BACK.**

- Upper
- Lower
- Tailbone
- Muscle Spasms
- Arthritis
- Disc Problems (Slipped)
- Feels Out of Place

**LOW BACK PAIN IS AGGRAVATED BY:**

- Lifting
- Stooping
- Standing
- Sitting
- Bending
- Coughing
- Walking
- Lying Down (Sleeping)
- Other: \_\_\_\_\_

Pain is Relieved by: \_\_\_\_\_  
\_\_\_\_\_

**HIPS.**

- Pain in Joint: R L
- Pain in Side: R L

**BUTTOCKS.**

- Pain: R L

**LEGS.**

- Pain: R L
  - Front
  - Back
  - Side
    - Inside
    - Outside
- Leg Cramps: R L
- Numbness: R L
- Pins and Needles: R L

**MEN ONLY.**

- Any difficulty urinating? Y N
- Any difficulty starting the flow? Y N
- Any prostate problems? Y N
- Date of last prostate exam \_\_\_\_\_

**KNEES.**

- Pain: R L
  - Inside
  - Outside
- Swelling
- Popping
- No Support

**ANKLES.**

- Pain: R L
- Swelling: R L

**FEET.**

- Pain: R L
- Feet Feel Cold
- Numbness in Feet: R L
- Swollen Feet: R L
- Cramping

**TOES.**

- Numbness: R L
  - Which Toes?
  - Big Toe 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> Little

**ABDOMEN.**

- Nervous Stomach
- Nauseous
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

**GENERAL.**

- Nervous
- Irritable
- Very Tired
- Depressed
- Moody

Normal Sleep is \_\_\_\_\_ hours per night.

Any Loss of Sleep Lately? \_\_\_\_\_

Any Loss of Weight Lately? \_\_\_\_\_

Any Gain of Weight Lately? \_\_\_\_\_

**WOMEN ONLY.**

Menstrual cycle is \_\_\_\_\_ days.

Any cramping? \_\_\_\_\_ Yes \_\_\_\_\_ No

Regular or irregular? \_\_\_\_\_

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ FILE # \_\_\_\_\_

IN ORDER FOR US TO HELP ASSESS YOUR CONDITION, WE NEED TO KNOW A FEW THINGS ABOUT YOUR FAMILY HISTORY. FIRST, FILL IN THE AGES OF EACH FAMILY MEMBER. IF DECEASED, LIST THE AGE THEY DIED. USE THE LETTER "P" TO INDICATE A PAST PROBLEM. USE THE LETTER "C" TO INDICATE A CURRENT PROBLEM. LEAVE BLANK THOSE SPACES THAT DO NOT APPLY. IF YOU REQUIRE MORE SPACE, USE THE REVERSE SIDE OF THIS FORM.

**FAMILY HEALTH HISTORY**

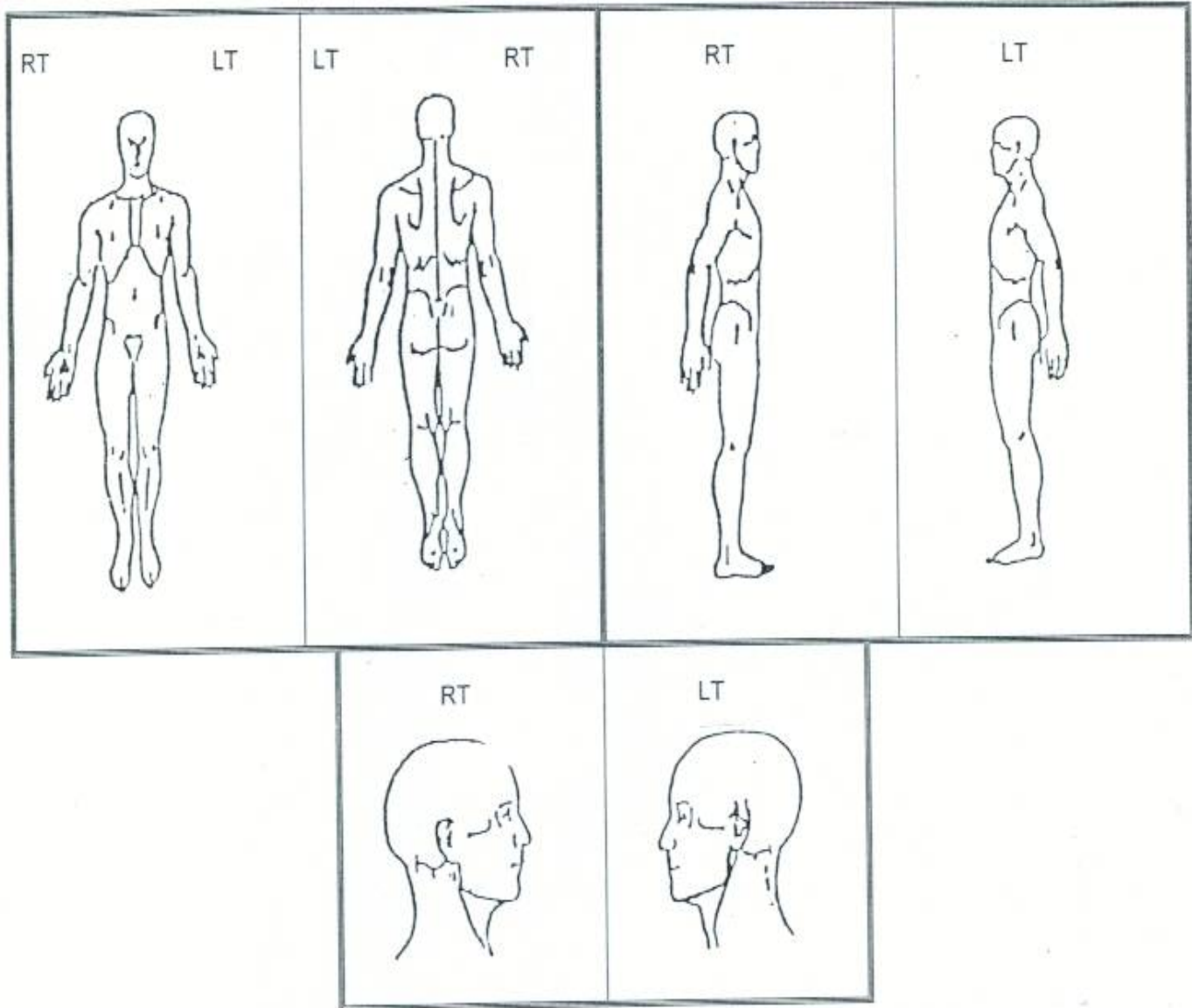
CONDITION	Father	Mother	Spouse	Brother(s)		Sister(s)		Child(ren)	
	Age_	Age_	Age_	Age_	Age_	Age_	Age_	Age_	Age_
Arthritis									
Asthma									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emotional Problem									
Emphysema									
Epilepsy									
Hay Fever									
Headaches									
Heart Trouble									
High Blood Pressure									
High Cholesterol									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ FILE # \_\_\_\_\_

**P...for pain; N...for numbing; T... for tenderness; S...for spasms and tight muscles**

*The Doctor needs to know more about your complaints, so please mark the areas on the "Body Figures" to show where you are currently experiencing your problems. Color in the area first and then put the following symbols next to the area:*

**P**...for pain; **N**...for numbing; **T**...for tenderness; **S**...for spasms and tight muscles



Have you ever had any prior treatments or complaints about the symptoms you are presently experiencing?  No  Yes Explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ FILE # \_\_\_\_\_