SPORTS CHIROPRACTIC
AND NATURAL HEALTH SOLUTIONS

NEW PATIENT INTAKE FORM

Name: _____
Last

_____
First MI

Address: _____

_____
City State Zip

Birthdate: _____/_____/_____ Sex: M_____ F_____

Home #: (_____) _____

Cell #: (_____) _____

Marital Status: _____

Email Address: _____
*For E-mail confirmations

Emergency Contact: _____
Name
(_____)_____

Primary Care Physician*: _____

Primary Care Physician Phone: (_____)_____
*My we contact him/her to let them know you are treating with us? Y or N

Occupation:_____

Whom may we thank for referring you:_____

Reason for your visit:_____

When did your symptoms begin? _____

Which describes the frequency of your discomfort?

Constant (100-76% of time awake) Intermittent (75-51%)

Occasional (50-26%) Rare (25-1%)

Is your pain (circle one or more**)**

Worse in the morning Worse in the afternoon

Worse at night Changing with the weather

Constant and does not change

What helps *relieve* your discomfort? (Circle one or more)

Ice Heat Medication

Other (please describe): _____

Circle the activities that are limited by your discomfort?

Bending Daily Routine Driving Lying Down

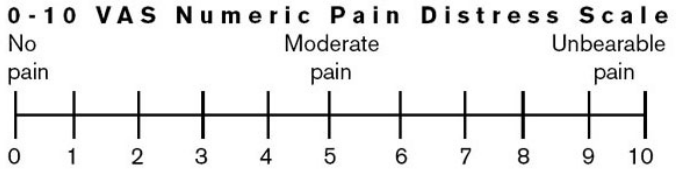
Sitting Sleeping Standing Walking Working

Other (please describe): _____

Your work activity includes: (circle all that apply)

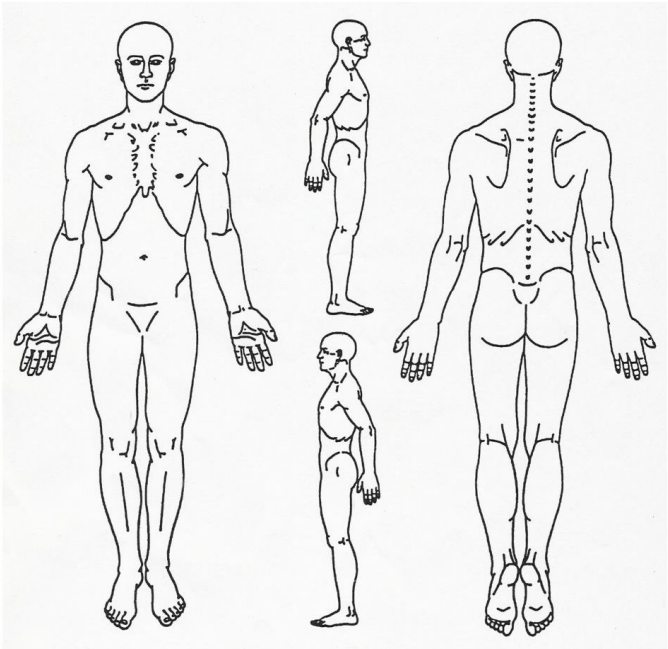
Sitting Standing Light Labor Heavy Labor

How would you rate your pain?



Use the chart below to mark where your pain is and the type of pain

A = Ache	B = Burning	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



Is this condition due to an accident? Yes_____ No_____

If yes, Date:_____/_____/_____

Type: Auto_____ Work:_____ Home:_____

To whom have you made a report of you accident?

Auto Ins._____ Employer_____ Worker Comp_____

Attorney Name:_____

☐ Check this box if you would like a list of trusted professionals in the community that our office recommends.

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Please list any:

Medications **Allergies** **Vitamins**

_____

_____

_____

Please list prior injuries, descriptions and when they occurred

Falls: _____

_____

Broken Bones: _____

_____

Dislocations: _____

_____

Surgeries: _____

_____

Do you smoke cigars and/or cigarettes? Yes No

If yes, how much do you smoke? _____packs/_____

How many alcoholic beverages do you consume per **week**? _____

How many days a week do you exercise? _____

Are you pregnant? No _____ Yes_____ Due Date _____

When was your last menstrual cycle? (month / year) _____/_____

Specify the date of your most recent: (month / year)

Physical Exam: _____/_____ Dental X-rays: _____/_____

Spinal X-ray: _____/_____ CT Scan: _____/_____

MRI:_____/_____ Other Scans or X-Rays:_____/_____

What treatment, if any, have you already received for your condition? (Circle all that apply)

Surgery Chiropractic Service Medications

Physical Therapy None Other_____

Name and number of any doctor(s) who have treated your condition:

_____

_____

Please mark "**Yes**" or "**No**" to indicate if you have had any of the following:

	Yes No		Yes No
Anemia	___ ___	Cataract	___ ___
AIDS/HIV	___ ___	Eczema	___ ___
Hepatitis	___ ___	Glaucoma	___ ___
Hypertension	___ ___	Arthritis	___ ___
Hypotension	___ ___	Gout	___ ___
Stroke	___ ___	Herniated Disc	___ ___
Chicken Pox	___ ___	Multiple Sclerosis	___ ___
Crohn's Disease	___ ___	Polio	___ ___
Diabetes	___ ___	Parkinson's Disease	___ ___
Headaches	___ ___	Pinched Nerve	___ ___
Fibromyalgia	___ ___	Gonorrhea	___ ___
Kidney Disease	___ ___	Herpes	___ ___
Liver Disease	___ ___	Digestion Issues	___ ___
Measles	___ ___	Constipation	___ ___
Mumps	___ ___	Bloating	___ ___
Shingles	___ ___		

Please write if you have had any issues with the following body systems in the past 6 months:

Skin: _____

Neurological: _____

Eyes/Ears/Nose/Throat: _____

Endocrine: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal: _____

Genitourinary: _____

Blood: _____

Musculoskeletal: _____

Allergic/Immunologic: _____

Have you ever diagnosed with any Cancer / Tumor? Yes No

If Yes, What type? _____

Vitals (Office Staff Use Only)

Height: _____'_____" Weight: _____ lbs.

Blood Pressure: _____/_____ (R or L arm) Pulse: _____BPM

Temperature: _____^{o}F Respiratory: _____BPM

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