Patient Intake Form

NORTHLAKE CHIROPRACTIC

Today's Date:_______________ Referred by:____

Last Name:_____________________________________ First Name:______________________ SSN:___________________

Address:____ DOB:__________________

City:_______________________________________ State:____________ Zip:___________ Gender: M or F

Home Phone:________________ Cell Phone:______________ Email:____

Occupation:____________________________Employer:______________________________Work Phone:_______________

Employer Address:____

Marital Status:__________ Spouses Name:_______________________ Spouse's Employer:____________________________

Emergency Contact:____ Phone:____________________________________

Do you have children? Yes or No How many?__________

Have you been to a Chiropractor before: Yes or No Who:____

When:___________________________ Reason for care:____

Who is your Medical Doctor?____ Phone #:________________________

INSURANCE INFO

Primary Insurance:____

Claims Address:____ Phone #:____________________________

Effective Date:_________________ Policy #:______________________ Group #:_____________________________________

Relationship to Insured:_______________ Insured Name:___________________________ Insured DOB:_________________

Secondary Insurance:____

Claims Address:____ Phone #:______________________________

Effective Date:__________________ Policy #:_______________________ Group #:__________________________________

Relationship to Insured:_______________ Insured Name:___________________________ Insured DOB:_________________

REASON FOR TODAY'S VISIT

What is your present complaint?____ Date Started:___________________

Is this condition due to: (Circle) Auto Accident Work Injury Other Accident Illness Unknown

Please describe your injury/reason for seeking chiropractic care: ____

____

Is your condition interfering with your: (Circle) Work Sleep Daily Routine: If so, how: _________________________

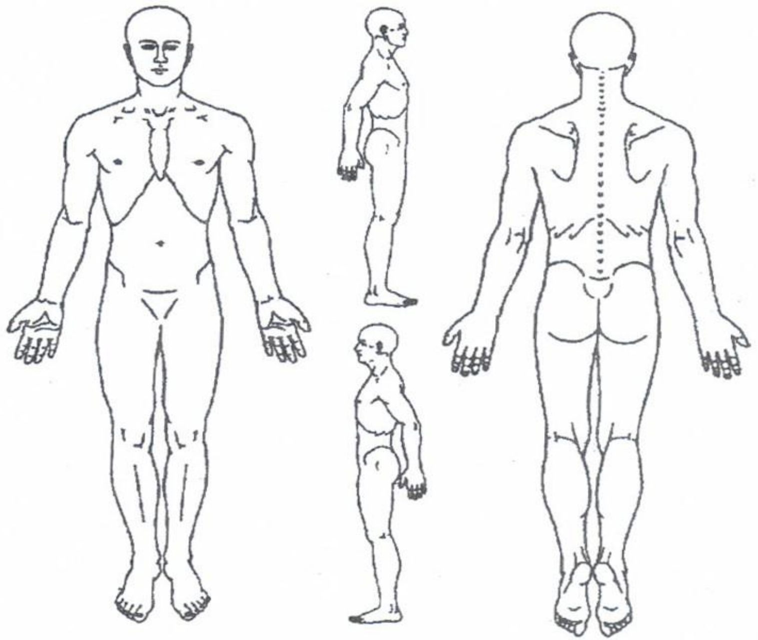
____

AREAS OF INJURY OR DISCOMFORT:

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

What aggravates your condition(s): (Circle) Standing Twisting Bending Sitting Lying Walking Coughing Lifting

By using the key below, indicate on the body diagram where you are experiencing the following symptoms: (Mark all the areas with the appropriate symbols, circle an area of pain not represented by a symbol).



N = Numbness A = Aching B = Burning
P = Pins & Needles S = Stabbing

Are your symptoms: ____ Improving
____ About the same
____ Getting worse

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Have you had these symptoms before? Yes No

HEALTH HISTORY

Major surgeries:____
Hospitalizations:____
Accidents or falls:____
List all prescriptions you now take:____
List all NON-prescription drugs you now take:____
List anything you are allergic to:____
Do you use tobacco (cigarettes/chew): Yes No If so, how much?___________________ How long?_________________
Do you drink alcohol: Yes No If so, how much? ___________________________ How often?________________________
Do you use recreational drugs: Yes No If so, which ones?______________________________ How often:______________
Do you exercise: Yes No If so, how many hours per week?_________________
Do you currently wear: Shoe lifts Inner soles Arch supports

For Women: Are you pregnant? Yes No If so, how many weeks?__________ Are you nursing? Yes No

Please check any of the following that you currently have or have had in the past:

__ Headaches
__ Sinus/Allergies
__ Asthma
__ Arthritis
__ Sciatica/Buttock pain
__ Heart Disease
__ Heart Murmurs
__ Diabetes
__ Stroke
__ Cancer
__ Bronchitis
__ Pulmonary disease
__ Emphysema
__ Pneumonia
__ Kidney stones
__ Gastric Ulcers
__ Colitis/Spastic Colon
__ Acid reflux
__ ADD/ADHD
__ Difficult/painful urination
__ Hiatal hernia
__ Premenstrual Pains
__ Joint pain
__ Jaw pain
__ Shoulder pain
__ Numbness
__Hepatitis A, B, C
__ HIV/AIDS
__ Fractures
__ Thyroid problems
__ Fatigue
__ Depression/Psychiatric Illness
__ Chest Pains
__ Stomach Problems
__ High blood pressure/hypertension
__ Low blood pressure/hypotension
__ Dizziness
__ Skin problems

I hereby authorize the doctor(s) and the staff of Northlake Chiropractic to administer any treatments and testing necessary for the purpose of improving my physical condition. The above patient information is true and accurate to the best of my knowledge.

____ _____________________ ___________
Patient Signature (custodial parent or legal guardian if patient is a minor) Relationship to patient Date