Patient Intake Form

For Office Use Only
Date: ______________
Acct #: ______________

Name: ______________________________

Address ______________________________ Preferred Language ______________________________

City ______________________ State ________ Zip ________ Home Phone ______________________

Cell Phone ______________ Email ______________________________ Ethnicity ______________

Sex ❑Male ❑Female Age ______ Birth date ____________ ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

Social Security # ______________________ Referred by ______________________________

Patient Employed By ______________________________ Occupation ______________________________

Business Address ____

Business Phone ______________________ Business Email ______________________________

Notify in Case of emergency ______________________ Home Phone ______________ Work Phone ______________

Cell Phone ______________ Email ____

Person Responsible for Account ____

Relation to Patient ______________________ Birth date ____________ Soc. Sec. # ______________

Person Responsible Employed By ______________________ Occupation ______________________

Insurance Company ____

Phone ______________________________ Email ______________________________

Contract # ______________________________ Group # ______________________________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies: ____

❑Medications: ____

Were you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________ Transported by? ❑Ambulance ❑Police ❑Other: ______________

Date Admitted: ____________ Date Released: ____________ Length of Stay: ____________

List the hospital procedures received: ____

Patient Name:_____ Date:_____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: _____

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: _____ To: _____

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____

What type of work do you do?_____

_____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

List any past conditions you may have had: _____

HABITS

❑ Drinking Alcohol: (Cups/day): _____

❑ Coffee Cups/Day: _____

❑ Soft Drink Bottles or Cans/Day: _____

❑ Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑_____
Father	❑	❑	❑	❑_____
Brother(s)	❑	❑	❑	❑_____
Sister(s)	❑	❑	❑	❑_____

Do you currently smoke tobacco of any kind? □Yes □Former Smoker □Never been a smoker

If yes, how often do you smoke: □Current everyday smoker □Current sometimes smoker

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? ❑Yes ❑No

If yes, which ones?: _____

_____

_____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies (including medications)? ❑Yes ❑No If yes, please explain: _____

_____

_____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

_____

_____

_____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

Patient Name:_____ Date:_____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy (What) ____
  _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors
- ❑ Twitching

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Shuttleworth Chiropractic Centre uses Electronic Health Records and you will have the ability to access your clinical summaries via the internet. You can use this to make sure we have an updated list of your medications, allergies, personal information and diagnosis, along with being able to print off for your own personal records or another doctor's records.

☐ **Yes**, I would like to have this information available for my own personal access.

☐ **No**, I would not like to have this information available for my own access.

Patient's/Guardian's Signature: _____ **Date:** _____

Witness: _____ **Date:** _____