Steele Chiropractic New Patient Intake Form

Patient Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Secondary Phone: _____

DOB: _____ Sex: Male or Female SSN#: _____

Occupation: _____ Employer: _____ Spouse Name:_____

Patient Condition: How did you hear about us:_____

Reason for visit: _____

When did symptoms start? _____ Experienced before? ◯ yes ◯ no

Improvement: ◯ better ◯ worse ◯ same

Rate pain on a scale of 1(least pain) to 10(severe pain) _____

Type of pain: ◯ dull ache ◯ sharp/stabbing ◯ shooting ◯ tightness ◯ burning ◯ tingling

◯ numbness ◯ radiating to_____

Frequency: ◯ intermittent ◯ occasional ◯frequent ◯ constant

What makes it better: ◯ ice ◯ heat ◯ pain meds ◯ massage ◯ rest ◯ stretching ◯ nothing

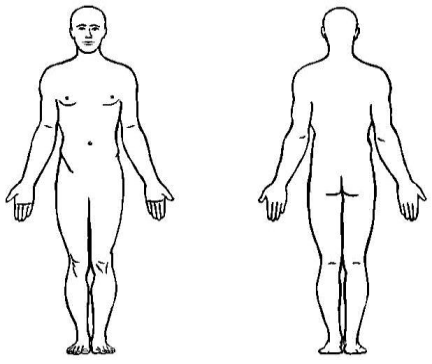
What makes it worse: ◯ sitting ◯ stand ◯ bend ◯ lift ◯ walking ◯ exercise ◯ work ◯ nothing

◯ daily routine ◯ recreation ◯ sleep ◯ other_____

Previous treatment: ◯ medications ◯ surgery ◯ therapy ◯ chiropractic

Previous x-rays or MRIs and findings: _____

Mark pain area on the drawing



About You:

Height: _____ Weight: _____

Current Meds (name and reason): _____

_____

_____

Any Surgeries (birth to present): _____

Any Allergies: _____

Pregnant? ◯ Yes ◯ No

Preferred Language:_____ Race:_____ Ethnicity:_____ Smoking Status:_____

Medical History:

General: ◯ Allergies ◯ headaches/migraines ◯ dizziness ◯ fatigue ◯ fainting/seizures

◯ weight loss/weight gain ◯ depression ◯ cancer (type)_____

◯ HIV/AIDS ◯ thyroid problems ◯ liver/gallbladder problems ◯ drug/alcohol dependence

◯ diabetes ◯ eczema, dermatitis, psoriasis

Muscle/Joint: ◯ arthritis ◯ RA ◯ neck pain ◯ mid back pain ◯ lower back pain

◯ joint pain (i.e. knee)_____

◯ scoliosis ◯ osteopenia/osteoporosis ◯ rib pain ◯ sprain/strain ◯ fibromyalgia

Cardiovascular: ◯ high blood pressure ◯ heart attack ◯ stroke ◯ rapid heartbeat ◯ chest pains

◯ aneurysm ◯ poor circulation

Neurological: ◯ concussion ◯ sciatica ◯ right ◯ left ◯ pinched nerve ◯ arm/hand tingling

GI: ◯ constipation/irregular bowel habits ◯ diarrhea ◯ IBS ◯ Crohn's ◯ Celiac's ◯ ulcer

◯ heartburn/acid Reflux ◯ abdominal pain ◯ hemorrhoids

Respiratory: ◯ asthma ◯ emphysema ◯ chronic cough ◯ drainage

Genitourinary: ◯ frequent/painful urination ◯ bladder infection ◯ kidney stones ◯ prostate problems

◯ loss of bladder control ◯ PMS ◯ Endometriosis

◯ Profuse/irregular menstrual flow ◯ Breast lumps

EENT: ◯ chronic sinusitis ◯ difficulty swallowing ◯ ringing in the ears/tinnitus ◯ vision problems

◯ ear infections

Any other health concerns not listed: _____

Family History: check box and indicate which relative(s)

Cancer _____ Heart problems_____ _____

Diabetes_____ Rheumatoid arthritis_____

Lung problems_____ Chronic back problems_____

Chronic headaches_____ High blood pressure _____

Authorization:

I affirm that the information I have given is correct and accurate to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____