**NEW PATIENT INTAKE**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We use text messaging for appointment reminders. Who is your cell phone company?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work address: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

Single\_\_\_\_\_\_\_\_ Married\_\_\_\_\_\_\_\_\_ Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance? Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a Chiropractor before? Yes No If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR HEALTH SUMMARY**

C:\Program Files (x86)\Microsoft Office\MEDIA\OFFICE14\Bullets\BD21301_.gifPlease check all symptoms you have ever had, even if they do not seem related to your current problem.

 Headaches

 Neck Pain

 Dizziness

 Sleeping problems

 Pins and needles in arms

 Numbness in fingers

 Fatigue

 Cold Sweats

 Mood Swings

 Loss of smell

 Buzzing in ears

 Depression

 Neck Stiff

 Lights Bother Eyes

 Fainting

 Loss of taste

 Irritability

 Cold Hands

 Fever

 Loss of balance

 Nervousness

 Tension

 Hot Flashes

 Mid back pain

 Stomach upset

 Heartburn

 Ulcers

 Asthma

 Low Back Pain

 Pain down legs

 Pins and Needles in legs

 Constipation

 Numbness in toes

 Menstrual Pain

 Problem urinating

 Menstrual Irregularity

 Cold Feet

List any medications you are taking

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability:

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature Date Guardian Signature Date

**Functional Rating Index**

For use with **Neck** and/or **Back** related problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

**1. Pain Intensity 6. Recreation**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No | Mild | Moderate | Severe | Worst | No | Mild | Moderate | Severe | Worst |
| pain | pain | pain | pain | possible | pain | pain | pain | pain | possible |
|  |  |  |  | pain |  |  |  |  | pain |

1. **Sleeping 7. Frequency of Pain**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Perfect sleep | Mildly disturbed | Moderately disturbed | Greatly disturbed | Totally disturbed | No pain | Occasional pain; | Intermittent pain; | Frequent pain; | Constant pain; |
|  | sleep | sleep | sleep | sleep |  | 25%  of the day | 50%  of the day | 75%  of the day | 100%  of the day |

1. **Personal Care (washing, dressing, etc.) 8. Lifting**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No pain | Mild pain | Moderate pain; need | Moderate pain; need | Severe pain; need | No pain | Increased pain with | Increased pain with | Increased pain with | Increased pain with |
| no | no | to go slowly | some | 100% | w/heavy | heavy | moderate | light | any |
| restrictions | restrictions |  | assistance | assistance | weight | weight | weight | weight | weight |

1. **Travel (driving, etc.) 9. Walking**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No | Mild | Moderate | Moderate | Severe | No pain | Increased | Increased | Increased | Increased |
| pain on | pain on | pain on | pain on | pain on | any | pain after | pain after | pain after | pain with |

long trips long trips long trips short trips short trips distance 1 mile 1/2 mile 1/4 mile all

walking

1. **Work 10. Standing**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Can do | Can do | Can do | Can do | Cannot | No pain | Increased | Increased | Increased | Increased |
| usual work | usual work | 50% of | 25% of | work | after | pain | pain | pain | pain with |
| plus unlimited | no extra | usual | usual |  | several | after several | after | after | any |
| extra work | work | work | work |  | hours | hours | 1 hour | 1/2 hour | standing |



Printed

Signature Date

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