Pro-Health Chiropractic & Integrative Center
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Patient Intake Form

Date:_____

First Name:_____ Middle Initial:_____ Last Name:_____

What do you prefer to be called?_____

Home Address:_____ City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ ☐ Ok to leave messages on: Home Cell Work

Sex: ☐Male ☐Female | Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Unknown ☐Minor

Date of Birth:_____ Social Security Number:_____

Employer:_____ Job Description:_____

How did you hear about the doctor: _____

Spouse/Significant Other:_____ Date of Birth:_____

Emergency Contact Name and Number:_____

Responsible Party:

Name of person responsible for this account:_____

Relationship to patient:_____ DOB:_____ Phone Number:_____

Address:_____ City, State, Zip:_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Please briefly describe your chief complaint:_____

When did you first notice the symptoms?_____

What are these symptoms preventing you from doing?_____

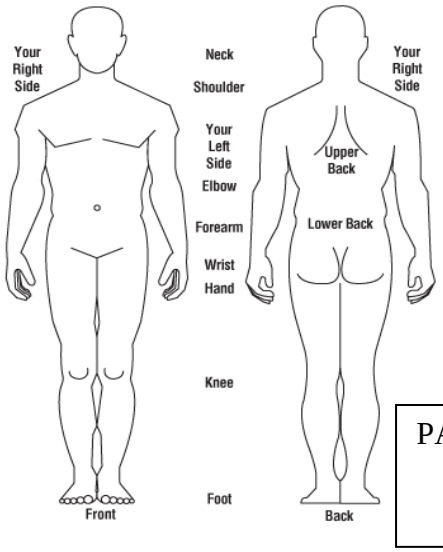
Do your symptoms interfere with: ☐ Work ☐Sleep ☐Walking ☐Sitting ☐Bending ☐Lifting

If you are experiencing pain, is it: ☐Sharp ☐Dull ☐ Comes and Goes ☐Travels ☐Constant

Since the problem started, it is: ☐About the Same ☐ Getting Better ☐Getting Worse

What makes it worse? And better, if anything?_____

Other Doctors seen for this problem (please list):_____



Place an "X" on the drawing to the left wherever you have pain.
Beside the "X" indicate the type of pain you are experiencing:

A- Ache	ST- Stabbing
B- Burning	SP- Spasm
N- Numbness	P- Pins and Needles
T- Throbbing	

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE

ACTIVITIES OF DAILY LIVING

Please circle the number to select the most appropriate statement. 0 = Able to function / 10 = Unable to function

Family/Home Responsibilities (chores, duties around the house): 0 1 2 3 4 5 6 7 8 9 10

Recreation/Social Activity (hobbies, sports, social functions): 0 1 2 3 4 5 6 7 8 9 10

Occupation (activities directly related to one's job): 0 1 2 3 4 5 6 7 8 9 10

Self Care (personal maintenance and independent daily living): 0 1 2 3 4 5 6 7 8 9 10

YOUR HEALTH PROFILE

Do you drink water daily? Y N How much:_____

Do you drink caffeine? Y N □How much:_____

Do/did you smoke? Y N □How much:_____

Do/did you drink alcohol? Y N □How much:_____

Do you take any supplements? Y N □What kind/which:_____

Do/did you play any adult sports? Y N □Which:_____

Do you exercise regularly? Y N □Type:_____

How old is your mattress?___yrs. How many pillows do you sleep with?___

Do you sleep on your back / front / side (circle all that apply)

Women: Are you pregnant? Yes No Taking Birth Control Pills? Yes No

PAST HISTORY

Have you had any illnesses in the past?_____

_____

Have you had any injuries in the past?_____

_____

Have you been hospitalized?_____

Have you had ANY surgeries?_____

_____

Have you been in an auto accident?_____

List any medications you are taking:_____

Family History:_____

CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gall Stones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disorder
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other (please list)

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

<u>Muscles & Joints</u>

- ☐ Low Back Pain
- ☐ Pain Between Shoulder Blades
- ☐ Neck Pain/Stiffness
- ☐ Arm/Elbow/Wrist Pain
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw
- ☐ Leg/Knee/Foot Pain
- ☐ Hip Pain
- ☐ Pain in Tailbone

<u>Eye, Ear, Nose & Throat</u>

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Swollen Glands
- ☐ Frequent Colds

<u>General Problems</u>

- ☐ Fatigue
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Weakness
- ☐ Migraines

<u>Heart & Lungs</u>

- ☐ Wheezing/Bronchitis
- ☐ Chest Pain
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Heart Surgery
- ☐ Lung Congestion
- ☐ Coughing
- ☐ Spitting Blood
- ☐ Varicose Veins
- ☐ Ankle Swelling

<u>Stomach/Intestines</u>

- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Poor Digestion
- ☐ Hemorrhoids/Piles

- ☐ Liver Trouble
- ☐ Gall Bladder
- ☐ Weight Trouble
- ☐ Stomach Cramps
- ☐ Stomach Pain
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Diarrhea
- ☐ Constipation

Kidney/Bladder

- ☐ Painful Urination
- ☐ Excessive Urine
- ☐ Discolored Urine
- ☐ Bedwetting
- ☐ Bad Urine Control

Nervous System

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions/Seizures
- ☐ Cold Extremities

Women

- ☐ Menses Irregular
- ☐ Menstrual Cramps
- ☐ Vaginal Pain
- ☐ Breast Lumps
- ☐ Pain During Sex
- ☐ Infertility
- ☐ Miscarriage

Men

- ☐ Prostate Pain
- ☐ Impotence
- ☐ Infertility

The statements made on this form are accurate to the best of my knowledge.

_____ _____

Signature Date

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy. Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____

Patient's Signature