Pro-Health Chiropractic & Integrative Center
Bruno Da Rocha, DC, CCSP
2100 East Hallandale Beach Blvd, Office 402
Hallandale Beach, FL.33009
Email: drbruno@drdarocha.com
Phone: (954) 391-8811
Fax: (954) 391-8796

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?____

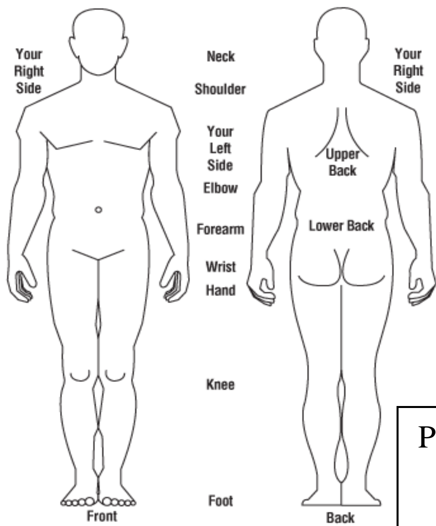
Do your symptoms interfere with: ☐ Work ☐Sleep ☐Walking ☐Sitting ☐Bending ☐Lifting

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:

Muscles & Joints
- ☐ 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

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

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

Heart & Lungs
- ☐ 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

Stomach/Intestines
- ☐ 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

<u>Kidney/Bladder</u>

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

<u>Nervous System</u>

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

<u>Women</u>

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

<u>Men</u>

- ☐ Prostate Pain
- ☐ Impotence
- ☐ Infertility

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

____ ______________________

Signature Date

<u>CANCELLATION POLICY</u>

To avoid charges, Pro-Health Chiropractic & Integrative Center requests a minimum of 24 hours notice for cancellation. **A <u>$100 cancellation fee</u> for new patients, and <u>$60 cancellation fee</u> for existing patients, may be charged if you do not show up for your appointment.** We understand that appointments are sometimes missed due to unforeseen circumstances such as emergencies or obligations with family and work. This is done in fairness both to patients who would otherwise have wanted the appointment and to the Doctor. As a courtesy to everyone, I thank you for being prompt. Late arrivals can only be extended to the time remaining in the scheduled session.

I have read and understood the cancellation policy.

Patient's Name: ______________________________ Date: ______________

Patient's signature: ______________________________

Signature of Doctor: ______________________________