



New Patient Intake Form

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Today's Date: _____ Name: _____ DOB: _____

Address: _____ City: _____ SS#: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____ Sex: Male Female Status: M D S W

Would you like to have your appointments confirmed by: Text Message or Email?

Which cell phone carrier do you have? AT&T Sprint Nextel Verizon T-Mobile Virgin Mobile

Emergency Contact: _____ Phone: _____

Occupation: _____ Employer: _____

Who can we thank for referring you to us? _____

Primary Care Doctor: _____ City: _____

Is it okay for us to send a brief report to your physician? Yes or No

What is your major complaint: _____

How long have you had this condition? _____ Have you had this in the past? Yes or No

Do any positions make it better? _____

Do any positions make it worse? _____

Have you seen any other doctors or therapists for this condition? _____

What do you think caused this condition? _____

Surgeries: _____

Medications: _____

Vitamins/Supplements: _____

(Female Only) Is there any chance that you could be pregnant? Yes or No

Have you been under chiropractic care in the past? Yes or No

Review of Systems

Please put a "C" next to the conditions you currently are experiencing and a "P" next to the condition that you have had in the past.

Fever _____	Sinus Congestion _____	Nausea _____
Night Sweats _____	Dental Problems _____	Constipation _____
Hair Changes _____	Bad Tonsils _____	Diarrhea _____
Dry Skin _____	Trouble Swallowing _____	Bloody Stools _____
Allergies _____	Neck Stiffness _____	Incontinence _____
Mumps _____	Neck Masses/Lumps _____	Back Pain _____
Rheumatic Fever _____	Breast Lumps _____	Kidney Stones _____
Cancer _____	Breast Pain _____	Pain While Urinating _____
Phlebitis _____	Breast Changes _____	Seizures _____
Hypertension _____	Asthma _____	Hand Trembling _____
High Cholesterol _____	Cough _____	Weak Grip _____
Stroke _____	Short of Breath _____	Tingling _____
Liver Problems _____	Wheezing _____	Loss of Memory _____
Polio _____	Heart Murmur _____	Weight Loss _____
Prostate Problems _____	Rapid Heartbeat _____	Weight Gain _____
Gynecological Problems _____	Swollen Arms/Legs _____	Depression _____
Headache _____	Chest Pain _____	Anxiety _____
Head Injury _____	Varicose Veins _____	Drug Addiction _____
Tinnitus _____	Anemia _____	Alcoholism _____
Earache _____	Diabetes _____	Muscle Pain _____
Dizziness _____	Abdominal Pain _____	Joint Pain _____

Family History

Do any of your immediate family members have any of these conditions? Circle all that apply.

Cancer Diabetes Heart Disease Stroke High Cholesterol Hypertension Gestational Diabetes

Social History

Describe your daily activities: _____

Do you exercise? Yes or No What type? _____

Do you smoke? Yes or No Do you drink alcohol? Yes or No How much? _____

What do you expect from your care with us? _____

Mark the areas of your symptoms on the figure to the right.

Please use the following symbols.

Aches ^^^^ Numbness 0000 Pins/Needles *** Stabbing ////

Mark an "X" on the lines to describe how bad your symptoms are now?

_____ None Most Severe

How bad have they been in the past?

_____ None Most Severe

