



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

What is your shoe size? _____ 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: _____

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

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 _____	Trouble Swallowing _____	Constipation _____
Hair Changes _____	Neck Stiffness _____	Diarrhea _____
Allergies _____	Neck Masses/Lumps _____	Bloody Stools _____
Cancer _____	Breast Lumps _____	Incontinence _____
Phlebitis _____	Breast Pain _____	Back Pain _____
Hypertension _____	Breast Changes _____	Pain While Urinating _____
High Cholesterol _____	Asthma _____	Seizures _____
Stroke _____	Short of Breath _____	Hand Trembling _____
Liver Problems _____	Wheezing _____	Weak Grip _____
Prostate Problems _____	Heart Murmur _____	Tingling _____
Gynecological Problems _____	Rapid Heartbeat _____	Weight Loss _____
Headache _____	Swollen Arms/Legs _____	Weight Gain _____
Head Injury _____	Chest Pain _____	Depression _____
Tinnitus _____	Varicose Veins _____	Anxiety _____
Earache _____	Anemia _____	Muscle Pain _____
Dizziness _____	Diabetes _____	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

Surgeries: _____

Medications/Vitamins: _____

Are you pregnant? Yes or No

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

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? _____

What forms of treatment are you open to receiving? (circle all that apply)

Chiropractic Manipulation Physical Therapy Acupuncture Massage Therapy Nutritional Counseling

Chief Complaint History

Please fill out this form for **each area of symptoms** that you have. (e.g. If you have neck pain and low back pain, fill out one form for your neck and then a second form for your low back). If you are unsure or need assistance with filling out this form, please let us know by calling us at 224-653-8094 and we'll guide you.

What is your complaint: _____

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

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

What do you think caused this condition? _____

What activities or positions make it worse? _____

What activities or positions make it better? _____

Mark the areas of your complaint 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 has your symptoms been **at their worst?**

None Most Severe

What percentage of the time do you have symptoms? (circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

