



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

Employer: _____ Occupation: _____

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 US Cellular

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	_____	Breast Lumps	_____	Tinnitus	_____
Night Sweats	_____	Asthma	_____	Dizziness	_____
Bruise Easily	_____	Short of Breath	_____	Hand Trembling	_____
Eye Pain or Difficulties	_____	Heart Murmur	_____	Weak Grip	_____
Allergies	_____	Swollen Arms/Legs	_____	Tingling in Arms/Hands	_____
Cancer	_____	Chest Pain	_____	Tingling in Legs/Feet	_____
Heart Attack	_____	Varicose Veins	_____	Hypothyroid	_____
Hypertension	_____	Anemia	_____	Hyperthyroid	_____
High Cholesterol	_____	Diabetes	_____	Weight Loss	_____
Stroke	_____	Constipation	_____	Weight Gain	_____
TIA	_____	Diarrhea	_____	Depression	_____
Liver Problems	_____	Bloody Stools	_____	Anxiety	_____
Kidney Problems	_____	Urinary Incontinence	_____	Muscle Pain	_____
Prostate Problems	_____	Fecal Incontinence	_____	Joint Pain	_____
Gynecological Problems	_____	Pain While Urinating	_____	Rheumatoid Arthritis	_____
Earache	_____	Seizures	_____	Osteopenia	_____
Sinus Congestion	_____	Headache	_____	Osteoporosis	_____
Trouble Swallowing	_____	Head Injury	_____	STDs	_____

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

Surgeries: _____

Medications/Vitamins: _____

Fractures, Dislocations or Major Traumatic Injuries: _____

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

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 the nature of your complaint: _____

When did it start? _____ Have you had this in the past? Yes or No

Have you seen any other doctors or therapists for this condition? (circle all that applies)

Primary Care Physician Immediate Care Emergency Room Orthopedist Neurologist Pain Specialist Physical Therapist
Chiropractic Physician Massage Therapist

What do you think caused this condition? _____

What activities or positions make it worse? (circle all that apply)

Sitting Standing Laying on Back Laying on Stomach Laying on Side Walking Running Climbing Stairs Driving
Using Computer Bending Over Lifting Lifting Overhead Reaching Behind Back Using Hands

Other: _____

What activities or positions make it better? (circle all that apply)

Sitting Standing Laying on Back Laying on Stomach Laying on Side Walking Walking and Leaning on Cane or Shopping Cart
Ice Pack Heat Pack Stretching Massage Pain Creams Medication

Other: _____

How would you describe your symptoms? (circle all that apply)

Dull Ache Sharp Stabbing Shooting Numb Tingling Stiff

Other: _____

On a scale of 0 to 10, with 0 being the best and 10 being the worst, please rate the intensity of your symptoms? (circle one)

0 1 2 3 4 5 6 7 8 9 10

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

0-25% 25-50% 50-75% 75-100%