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### Chiropractic Patient Intake Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # (home / cell) \_\_\_\_\_ Email: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ female \_\_\_\_\_ male \_\_\_\_\_

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Partnership \_\_\_\_\_

Occupation / Employer \_\_\_\_\_ Hours per week \_\_\_\_\_

Health insurance company name, address, & phone #:

\_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy holder's name \_\_\_\_\_

Did you call your insurance to verify coverage? Yes / No

I certify that I, and/or my dependent(s) have coverage with the above named insurance company and assign directly to Dr. Sorensen all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agencies for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Print Patient/Guardian Name)

(Signature of Patient/Guardian)

(Date)

Emergency contact \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

#### Accident Information

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of Accident  Auto  Work  Home  Other

To whom you reported your accident?  Auto Insurance  Employer  Worker's Comp  Other

Attorney Name (if applicable) \_\_\_\_\_

### Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

What seems to be the initial cause? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No

Does it interfere with:  Work  Sleep  Daily Routine  Recreation

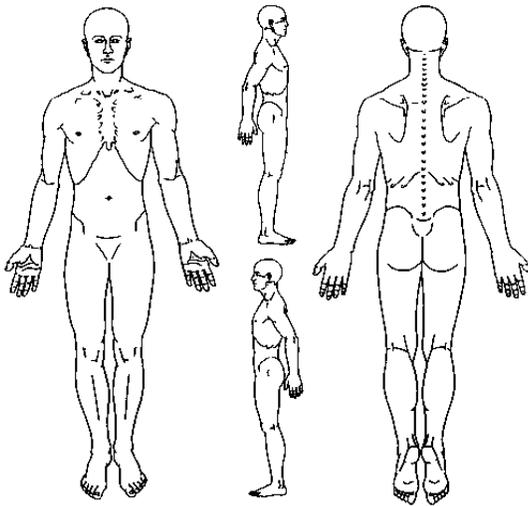
Activities that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down

Are you under the care of a Physician?  Yes  No If yes, for what reason? \_\_\_\_\_

Have you seen a Chiropractor?  Yes  No

Work Activity?  Sitting  Standing  Light Labor  Heavy Labor

Mark an X on the pictures where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain).

1 2 3 4 5 6 7 8 9 10

#### Type of pain:

- Sharp
- Throbbing
- Aching
- Burning
- Cramps
- Swelling
- Dull
- Numbness
- Shooting
- Tingling
- Stiffness
- Other

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### Hospitalizations, Surgeries, Diagnostic Studies

List previous hospitalizations and/or surgeries and date: \_\_\_\_\_

X-rays, CAT scans, or other studies you have had: \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_

Have you:  Broken a bone  Had a Sprain/Strain  Been struck unconscious

If yes, explain: \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_

### Current Medications / Supplements

Please list any prescription medications or over the counter medications you are taking. \_\_\_\_\_

Please list any vitamins, minerals, or nutritional supplements you are taking. \_\_\_\_\_

**REVIEW OF SYSTEMS  
FOR THE FOLLOWING, PLEASE CHECK**

**Y = Current Condition**

**N = Never**

**P = Condition of the Past**

**Y N P**

**Muscle / Joint**

**Muscle / Joint / Neurologic**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Neck pain, stiffness
- Numbness/tingling
- Neuralgia
- Muscle weakness
- Broken bones
- Sciatica
- Spinal curvature
- Muscle spasm/cramps

**General**

- Allergies
- Chills
- Fever
- Heat or cold intolerance
- Night sweats
- Convulsions
- Tremors
- Dizziness
- Fainting
- Fatigue
- Loss of sleep
- Loss of weight
- Anxiety
- Depression
- Memory problems
- Considered suicide
- Excessive thirst
- Excessive hunger
- Chronic infections
- Swollen glands
- Loss of balance
- Smoke cigarettes  
packs per day: \_\_\_\_\_  
how many years: \_\_\_\_\_
- Drink coffee  
cups/day? \_\_\_\_\_
- Drink alcohol  
drinks/day? \_\_\_\_\_
- Recreational drugs
- Treated for addiction
- Exercise?  
How often? \_\_\_\_\_
- Sleep well
- Awaken rested
- High stress level

**Cardiovascular**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Chest pain
- Poor circulation
- Palpitations
- Swelling of ankles
- Blood clots
- Easy bruising
- Deep leg pain

**Y N P**

**Eye, Ear, Nose and Throat**

- Asthma
- Colds
- Headaches
- Jaw/TMJ problems
- Earache
- Ear discharge
- Ear noise/ringing
- Enlarged glands
- Enlarged thyroid
- Eye pain/strain
- Impaired vision
- Dry eyes
- Tearing eyes
- Cataracts
- Glaucoma
- Gum problems
- Dental Cavities
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nose bleeds
- Sinus problems
- Sore throat
- Tonsillitis
- Lumps on neck
- Goiter

**Gastrointestinal**

- Belching or gas
  - Heartburn
  - Trouble swallowing
  - Constipation
  - Diarrhea
  - Difficult digestion
  - Bloating abdomen
  - Excessive hunger
  - Gallbladder trouble
  - Hemorrhoids
  - Gallbladder disease
  - Jaundice
  - Liver disease
  - Nausea
  - Abdominal pain
  - Poor appetite
  - Vomiting
  - Black stools
  - Blood in stool
- Bowel movements: how often?  
\_\_\_\_\_

**Genitourinary**

- Bed-wetting
- Blood in urine
- Frequent urination
- Frequent infections
- Painful urination
- Inability to hold urine
- Inability to urinate

**Y N P**

**Skin**

- Boils/Acne
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins
- Lumps

**Respiratory**

- Chest pain
- Cough
- Difficult breathing
- Shortness of breath
- Coughing up blood
- Coughing up phlegm
- Wheezing

**Men only**

- Hernias
- Testicular pain
- Venereal disease
- Sexually active
- Testicular mass
- Prostate disease
- Discharge or sores
- Impotence

**Women only**

- Age of first menses: \_\_\_\_\_  
Age of last menses: \_\_\_\_\_
- PMS
  - Painful menses
  - Excess menstrual flow
  - Abnormal PAP
  - Irregular cycle
  - Lumps in breast
  - Breast pain
  - Nipple discharge
  - Vaginal discharge
  - Menopausal symptoms
  - Infertility
  - Sexually active
  - Venereal disease

Birth control: \_\_\_\_\_  
Number of pregnancies: \_\_\_\_\_  
Number of live births: \_\_\_\_\_  
Are you pregnant?  Yes  No

*Check any of the following conditions you currently have or have had:*

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Bronchitis
- Cancer
- Chicken pox
- Cholera
- Cold sores
- Colitis
- Diabetes
- Diphtheria
- Eczema
- Edema
- Emphysema
- Epilepsy
- Fever blisters
- Goiter
- Gout
- Heart disease
- Herpes
- Influenza
- Lumbago
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Pacemaker
- Pleurisy
- Pneumonia
- Polio
- Rheumatic fever
- Scarlet fever
- Stroke
- Tuberculosis
- Typhoid fever
- Ulcers
- Venereal disease
- Whooping cough
- Hypothyroid
- Murmur

