Elbert Chiropractic
Wellness and Sports Medicine

Patient Intake Form

This form has a front AND back side

For those questions you are unsure of or feel don't apply to you - skip and complete this form to the best of your knowledge.

Date: _____

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthday: _____ Sex: *(check one)* M___ F___ **Marital Status:** *(check one)* Married___ Single___ Other___

Spouse Name: _____ Number of Children: ____ Chance Pregnant: Y___ N___ **Height: ____ Weight: _____**

Emergency Contact: _____ Relation: _____ Phone: _____

Referral Information

Referred By: *(check one)* Physician ___ Patient ___ Other ___ **Name of Referral: _____**

How did you hear about us? _____

Patient History

Last Physical Exam: *(month and year)* _____ **Primary Phys: _____ Phys City: _____ Phys State: ____**

Have you received chiropractic care in the past? *(check one*) Yes ___ No ___ - **IF YES- Date Received: _____**

Reason for Treatment: _____

Medications and Supplements: *(If you cannot remember, please bring an updated list at your next visit*) _____

_____

Please list any sprains/strains or broken bones *that are currently causing you pain* **in the space provided below (If none, leave blank):_____**

Please list any recent surgeries or hospitalizations: _____

Please list any previous illnesses: _____

Eating Disorder: *(check one*) Yes___ No___ **Stroke***: (check one)* Yes___ No___ **Struck Unconscious:** *(check one)* Yes___ No___
Auto Accident*: (check one)* Yes___ No___ **If you checked "Yes" for any of the four previous questions, please explain any treatment received in the space provided: _____**

Reason for Treatment

What brings you here today? _____

Current aches and/or pains*:* _____

When did this/these start to occur? _____

Specific event/events that may have onset aches/pains: _____

Do aches/pains radiate throughout your body? (*Please explain in space provided* →ex: (pain radiates from neck into right arm):

_____

_____

Rate the severity of aches/pains: *(circle number that best describes)* Mild → 1 2 3 Moderate → 4 5 6 Severe → 7 8 9 10

Frequency of aches/pains: *(check one)* Rarely (25%) ___ Occasionally (50%) ___ Frequently (75%) ___ Constant (100%) ___

Activities that relieve aches/pains: _____

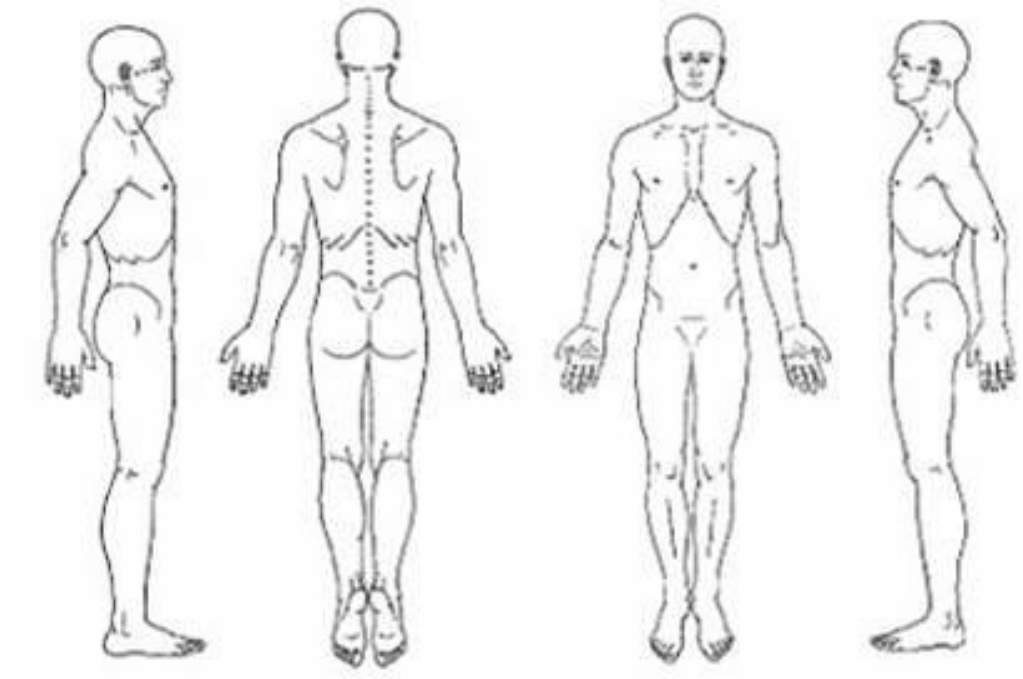
Activities that aggravate aches/pains: _____

Have aches/pains gotten better, worse or stayed the same over time? _____

Where is your pain located?

Please mark the location and character of your pain using the following symbols:

OO Dull **//** Sharp **^^** Stabbing **XX** Burning **++** Throbbing



Systems Review

Issues or complications with the following: *(Please check all that apply)* Bowel___ Bladder___ Digestion___ Tingling___ Numb___ Vision___ Heart___ Lungs___ Skin___ Hormones___ Other___

Describe any issues or complications checked above: _____

Daily Habits

How often do you use the following? *(Check frequency that applies)*

Alcohol: Daily___ Weekly___ Occasionally___ Never___ Caffeine: Daily___ Weekly___ Occasionally___ Never___

Recreational Drugs: Daily___ Weekly___ Occasionally___ Never___ Tobacco: Daily___ Weekly___ Occasionally___ Never___

Soft Drinks: Daily___ Weekly___ Occasionally___ Never___ Water: Daily___ Weekly___ Occasionally___ Never___

Current diet and nutrition habits*:* _____

Current exercise habits: _____

Employer Information

Employed: (check one) Full Time___ Part Time___ Unemployed___ **Job Title:** _____

Employer Name: _____ Employer City: _____ Employer State: _____

Patient Signature: _____ Date: _____