BI-COUNTY
CHIROPRACTIC AND REHAB
CHIROPRACTIC - MASSAGE - INJURY SPECIALIST

PATIENT INTAKE FORM

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PATIENT INFORMATION

Name:_____ Date:_____ Address:_____

Cell Phone:_____ Home Phone (if not cell):_____ E-mail:_____

SS# (for Medicare patients only):_____ Occupation:_____

Date of Birth:_____ Age:_____ Gender:_____ Marital Status:_____

How did you hear about us?_____

Spouse's Name:_____ Spouse's Occupation: _____ How many children do you have?_____

Emergency Contact:_____ Relationship to Patient:_____ Phone:_____

Primary Care Physician:_____ Have You Been To A Chiropractor Before? ❑ YES ❑ NO Last Visit? _____

INSURANCE INFORMATION (Skip if not utilizing insurance)

Primary Insurance:_____ Insurance ID#_____ Group#_____ Are you the primary policy holder? ❑ YES ❑ NO

Insured's Name:_____ Insured's DOB:_____ Insured's Phone:_____

Address:_____ Relationship to patient:_____

PATIENT CONDITION

Chief Complaint:_____

When did symptoms start?_____

How did symptoms start?_____

What makes it better?_____

What makes it worse? _____

How much of the day do you feel symptoms?

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Are the symptoms getting:

❑ Worse ❑ Better ❑ Staying the Same

Have you had anything like this before? ❑ YES ❑ NO

How would you describe your symptoms (check all that apply):

❑ Dull Ache ❑ Tightness ❑ Burning ❑ Sharp
❑ Numb ❑ Tingling ❑ Stabbing ❑ Shooting
❑ Throbbing ❑ Radiating, If Radiates, to where?:_____

Please rate the intensity of your symptoms from 0-10 with 10 being the worse possible:

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please select symptom intensity:

❑ Minimum ❑ Mild ❑ Moderate ❑ Severe ❑ Unbearable

What have you tried that makes the symptoms better? Please indicate:

❑ Medication ❑ Physical Therapy ❑ Surgery
❑ Chiropractic ❑ Massage Therapy ❑ Acupuncture
❑ Other:_____

What lifestyle activities does this interfere with? (check all that apply)

❑ Prolonged sitting ❑ Walking ❑ Prolonged standing
❑ Lifting ❑ Traveling ❑ Social/Recreational activities
❑ Bending ❑ Sleeping ❑ Personal care (washing, dressing, etc.)
❑ Other:_____

ADDITIONAL COMPLAINT (N/A if you have no 2nd Complaint)

Additional Complaint (if applicable)_____

When did symptoms start?_____

How did symptoms start?_____

What makes it better?_____

What makes it worse? _____

How much of the day do you feel symptoms?

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Are the symptoms getting:

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❑ Lifting ❑ Traveling ❑ Social/Recreational activities
❑ Bending ❑ Sleeping ❑ Personal care (washing, dressing, etc.)
❑ Other:_____

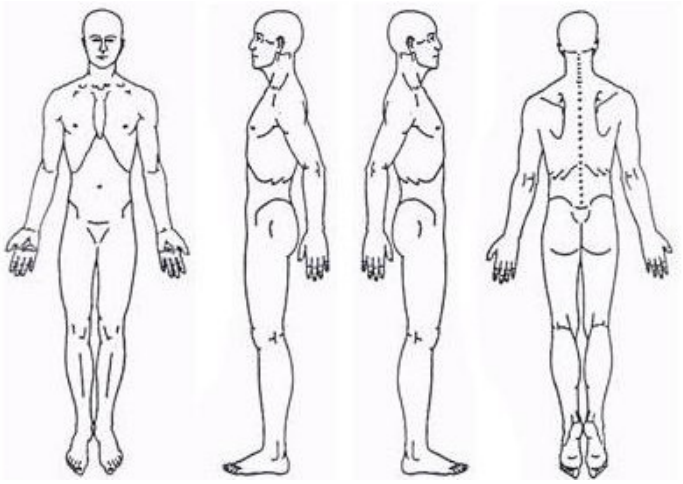
PATIENT PAIN DIAGRAM

Click area(s) of diagram to display painful/symptom location.

Please mark off the areas of your complaint(s) on the diagram. Use the following symbols of the pain diagram to accurately describe your condition.

PPP	Pain
NNN	Numbness
TTT	Tingling
BBB	Burning
CCC	Cramping

To be completed in office at the time of your appointment



HEALTH HISTORY

Are you pregnant? ❑ YES ❑ NO Do you have any implants, pacemakers, etc.? ❑ YES ❑ NO

Allergies:_____

List any surgeries, traumas, and/or hospitalizations (with approx. dates):

_____

_____

MEDICATIONS: Please list any medications you are taking for current symptoms

_____

Are you taking any blood thinners or statins? ❑ YES ❑ NO

(Please bring in a sheet of medications if taking additional meds)

PAST MEDICAL HISTORY

Past/Current Conditions

❑ Osteoporosis	❑ Anxiety/ Depression	❑ Dizziness/Vertigo	❑ Thyroid/Hormone Disorder
❑ Degenerative Arthritis	❑ Headaches/Migraines	❑ Sleeping Trouble	❑ High Blood Pressure
❑ Rheumatoid Arthritis	❑ History Stroke/Aneurysm	❑ Asthma/ Breathing Problem	❑ Convulsions/Epilepsy
❑ Heart Attack/Heart Disorder	❑ Cancer	❑ Digestive Trouble	❑ Prostate Problems
☒ Sinus Problems	❑ Diabetes	❑ Heartburn/Acid Reflux	❑ Fibromyalgia
❑ Born with bone/Joint disorder	❑ Autoimmune Disease	❑ Menstrual Problems	❑ Neurological Disorder

OTHER:_____

Family Health History (check any that apply):

❑ Auto-immune	❑ Cancer	❑ Thyroid	❑ Hypertension
❑ Arthritis	❑ Diabetes	❑ Heart disease	❑ Stroke

SOCIAL HISTORY AND LIFESTYLE

1. Smoking (packs/day) _____
2. Caffeine(drinks/day)_____
3. Alcohol (drinks/week)_____
4. Exercise (days/week)_____
5. Sleep (hours/night)_____
6. Rate your stress level (0 = No Stress, 10= High Stress)_____
7. Rate your overall health_____

Patient Signature _____ Date _____