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New Practice Member Intake Form

First Name: _____
Last Name: _____
Nickname: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Email: _____
Age: _____ Date of Birth: _____
Sex: () Male () Female
() Single () Married () Divorced () Separated () Widowed
Names and Ages of Children: _____

Social Security #: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

Type of work: _____
Insurance: () Work Comp () Auto () MA
Medicare () Private: _____
Whom may we thank for referring you to our office? _____
How were you referred to our office?
() Yellow pages () Lecture () Drive by
() Coupon () Screening = Where? _____

() Mailing = which one? _____
() Other: _____

Your Health Profile

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? _____

Name/Address/Phone of the last doctor who put you on a health development program? _____

Were you able to stay on the program? Y N How long? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Y N Not Sure

If so, what did you do to improve your health? _____

If not, why do you think your health declined? _____

Will you be healthier 5 years from now than you are today? Y N Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____

After making these changes in your life, how do you expect your health to be 5 years from now? _____

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

What was the duration of your care? _____

Were you aware that:

- Doctors of Chiropractic work with the nervous system? ___Yes ___No
- The nervous system controls all bodily functions and systems? ___Yes ___No
- Chiropractic is the largest natural healing profession in this world? ___Yes ___No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ___Yes ___No

What other wellness professionals are currently parts of your health care team? () Massage Therapist () Acupuncturist () Naturopath () Homeopath () Other: _____

How many Medical Doctor's office visits did you and your family have last year? () None () Less than 5 () More than 5 () More than 10

Is your current condition the result of a recent: () auto accident? () work related injury

What was the date of injury? _____

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/week () 3-4x/week () 5-6x/week () daily () other: _____

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? _____

Please describe the location of the pain. _____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

Is this problem getting: () worse? () better? () staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Secondary Complaint -- if any (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/week () 3-4x/week () 5-6x/week () daily
() other: _____

Please grade the intensity of this problem (with 10 being worse):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc)? _____

Please describe the location of the pain: _____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

Is this problem getting: () worse? () better? () staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Lifestyle / Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke?	Y	N	If yes, how much?	_____
Do you drink alcohol?	Y	N	If yes, how much?	_____
Do you drink coffee?	Y	N	If yes, how much?	_____
Do you drink tea?	Y	N	If yes, how much?	_____
Do you drink water?	Y	N	If yes, how much?	_____

How regularly do you exercise? () daily () ___x/week () occasionally () never

What kind of exercise do you do? _____

How many hours of sleep do you get on average? _____

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational _____

Personal _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____

When was your last period? _____

Are you pregnant? () Yes () No () Not sure

Medical History

Please list the cause of death and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following illnesses you have had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Eczema |

Surgeries:

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous injuries or trauma (please give type and date): _____

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Nutritional Supplements you are currently taking: _____

Allergies: _____

Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional)_____		

Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional)_____		

Please check any of the following you have had in the last six months:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Hearing Difficulty

GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after Meals
- Heartburn
- Black/Bloody Stools
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIO-VASCULAR- RESPIRATORY

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EYES, EARS, NOSE, THROAT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose

MALE / FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems:

Which best describes your reason for consulting our office?

- I have a specific concern and require help with this concern
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- I want to be healthier five years from now than I am today