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New Patient 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: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Whom may we thank for referring you to our office?_____
How were you referred to our office?
( ) Internet ( )Lecture ( )Drive by
( ) Coupon ( )Screening = Where?_____
( ) Other: _____

☐ **Email Opt-In**
Vitality Chiropractic and its affiliates can send me emails with offers, promotions and notifications.

In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

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? _____
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? _____

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? _____

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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? _____

Your Health Profile

What are your health goals? _____

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? _____

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.

(Women Only)

When was your last period? _____ Are you pregnant? ( ) Yes ( ) No ( ) Not sure

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

Please check any of the following illnesses you or a family member have or have had and describe their relationship to you:

(X)	*(relation)*	*(X)*	*(relation)*
____Lupus……..	_____	____Arthritis…….	_____
____Muscular Sclerosis…	_____	____Epilepsy…….	_____
____Parkinsons……	_____	____Cancer……..	_____
____Mental Disorders….	_____	____Thyroid Disorder……	_____
____Chicken Pox…….	_____	____Heart Disease……	_____
____Diabetes……	_____		

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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)_____		
			_____		

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 _____

Surgeries:

Approx. 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: _____

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:_____*(where)*
____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

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