1. New Patient Information

First Name: _____ Last Name: _____ DOB: _____

PATIENT INTAKE

Welcome to our online intake form. The information you provide will be sent directly to our office, streamlining your office visit and enabling us to better address your healthcare needs.

ABOUT YOU

2. Home Address: Please provide the address associated with your insurance.

Address 1 _____ Address 2 _____

City _____ State _____ Zip Code _____

3. Contact Information

Mobile Phone _____ Home Phone _____

Primary Email Address _____

4. Demographic Information

Sex at birth:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

5. Personal Information

Height - Feet: _____ Height - Inches: _____

Weight (in pounds): _____

6. Do you have insurance?

○ Yes ○ No

7. Insurance Payer

Insurance Payer _____

8. Insurance Policy Information:

Insurance Plan Name | ID/Policy Number: | Group Number:

Relationship to Patient:

○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: | Insured's Date of Birth:

9. Insurance Card Upload

10. Emergency Contact Information

Emergency Contact Name: | Contact Phone Number: | Relationship to Patient:

11. Referral Information

Referring Physician: | Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

AREAS OF CONCERN

12. What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern.

13. Rate the severity of your pain in the last 3 days.

Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

14. Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

_____

_____

_____

_____

15. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other, specify:

_____

16. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

_____

17. Have other health care provider(s) performed tests related to this condition?

○ Yes ○ No

If Yes, specify:

_____

18. Have you ever had any previous episodes of this condition?

○ Yes ○ No

If Yes, specify:

_____

19. Do you have an additional condition?

○ Yes ○ No

If Yes, specify:

_____

AREAS OF CONCERN

20. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

_____

21. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
None		
Other		

If other, specify:

_____

22. Have you ever had any previous episodes of this condition?

○ Yes ○ No

If Yes, specify:

_____

23. Do you have an additional condition?

○ Yes ○ No

24. Approximate date this condition began (exact date not required)

_____

What caused this condition?

_____

What is your additional area of concern?

_____

_____

25. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

_____

26. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

_____

How often do you feel this discomfort?

_____

How has this complaint changed since onset?

Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

27. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
None		
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
Other		

If other, specify:

28. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other,specify:

29. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

_____

30. Have other health care provider(s) performed tests related to this condition?

○ Yes ○ No

31. Have you ever had any previous episodes of this condition?

○ Yes ○ No

CURRENT HEALTH

32. Are you currently taking any medications?

○ Yes ○ No

33. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		

34. Other than the condition(s) already shared, do you have any additional health concerns?

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

35. If you have answered yes to any of the above, please share this info with your doctor.

36. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

PERSONAL AND FAMILY HISTORY

37. Please note any significant previous medical history.

	Yes	No
Have you had any surgical procedures?		
Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?		

38. If you have answered yes to any of the above, please share this info with your doctor.