NEW FRONTIERS
CHIROPRACTIC



# NEW PATIENT INTAKE FORM

## PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____

Relationship _____

Contact Number _____

**Who may we thank for referring you?** _____

## HOW CAN WE HELP YOU?

What brings you in today?

_____

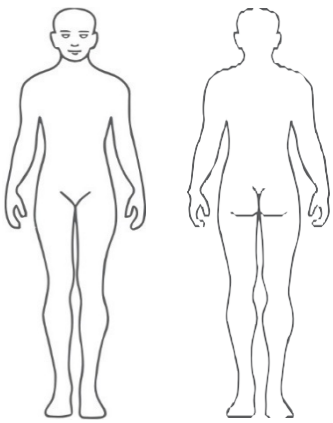
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

## IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

| | No Effect | Mild Effect | Moderate Effect | Severe Effect | | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|---|---|---|---|---|
| Work | ☐ | ☐ | ☐ | ☐ | Energy | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ | Attitude | ☐ | ☐ | ☐ | ☐ |
| Recreation | ☐ | ☐ | ☐ | ☐ | Patience | ☐ | ☐ | ☐ | ☐ |
| Relationships | ☐ | ☐ | ☐ | ☐ | Productivity | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ | Creativity | ☐ | ☐ | ☐ | ☐ |
| Self-Care | ☐ | ☐ | ☐ | ☐ | Other _____ | ☐ | ☐ | ☐ | ☐ |

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

## PATIENT WELLNESS ASSESSMENT

### ILLNESS-WELLNESS CONTINUUM


| DISEASE | POOR HEALTH | NEUTRAL | GOOD HEALTH | OPTIMAL HEALTH |
|---|---|---|---|---|
| Multiple medications<br>Poor quality of life<br>Potential becomes limited<br>Body has limited function | Symptoms<br>Drug therapy<br>Surgery<br>Losing normal function | No symptoms<br>Nutrition inconsistent<br>Exercise sporadic<br>Health not a high priority | Regular exercise<br>Good nutrition<br>Wellness education<br>Minimal nerve interference | 100% function<br>Continuous development<br>Active participation<br>Wellness lifestyle |

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

## CHILDREN AND PREGNANCY

How many children do you have? _____

Childrens' names & ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

## HEALTH & ILLNESS HISTORY

**Please check the box beside any condition that you have or have had:**

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis/Rheumatoid
- ☐ Asthma/Allergies
- ☐ Back/Neck Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Genetic Disease
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Fracture/Broken bone
- ☐ Other _____

## ALLERGIES, MEDICATIONS & SURGERY

| ALLERGIES (list) | MEDICATIONS/CONDITIONS (list) | SURGERY (list) |
|---|---|---|
| | | |
| | | |

**FAMILY HISTORY:**

Does anyone in your family been diagnoses with: □ Heart Disease □ High Blood Pressure □ Kidney Disease □ Lung Disease □ Diabetes □ High Cholesterol □ Asthma □ Cancer □ Stroke □ Alzheimer's/dementia □ Osteoporosis □ Genetic Disorder

Please list child, spouse, sibling, mother, and/or father and diagnosis: _____

_____

**EXPERIENCE WITH CHIROPRACTIC:**

Have you seen a Chiropractor before? □ Yes □ No Reason for visits: _____

Favorable outcomes? □ Yes □ No Explain: _____

Are you aware of any of your poor posture habits? □ Yes □ No Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No Have their spines been checked?

Explain: _____

**HEALTH LIFESTYLE:**

Do you exercise? □Yes □ No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

Do you smoke? □Yes □ No How much? _____

Do you drink alcohol? □Yes □No How much / week? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____