Chiro One Wellness Centers New Patient Intake Paperwork

1 Patient Information

First Name: ______________________ Last Name: ______________________ Middle Name: ________________

Email: ______________________ Primary Phone: ____________ Legal Sex: ______ Birthdate: __________ Age: ______

Address: ________________________________ City: ______________ State: __________ Zip: __________

2 Reason for coming in

Primary Reason for coming in: ____

How long have you experienced this? ____________ Most recent occurrence date: ____________

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: ______________________

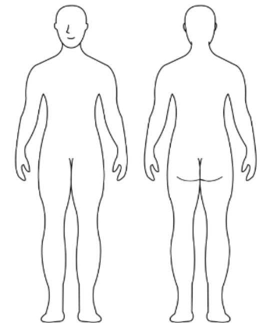
Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel? ____________________________________

How often does the pain occur? ____________ Does it seem to be getting progressively worse?: ☐ Yes ☐ No

What do you think caused the problem? ____________________________________

Indicate where on the figure



What activities make it worse?: ______________________ Worse in the morning or evening? ______________________

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down ☐ Bending/Squatting to lift object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/ OffChair ☐ Food Prep/Eating ☐ Reaching Over Head/ Across Body ☐ None ☐ Other: ______________________

Rate the severity of your pain at its worst (1- Least to 10-Severe): ______ Least severe (when you feel it): ______ Present moment: ______

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: ______________

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other: ______________________

What has helped/provided most relief? ____________________________________

3 Additional Concerns

Additional Concern 1: ______________________ How long have you experienced this? ______________

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: ______________ Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel? ______________________ How often does the pain occur? ______________

What activities make it worse?: ______________________ Worse in the morning or evening? ______________________

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down ☐ Bending/Squatting to lift object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/Off Chair ☐ Food Prep/Eating ☐ Reaching Over Head/ Across Body ☐ None ☐ Other: ______________________

Rate the severity of your pain at its worst (1- Least to 10-Severe): ______ Least severe (when you feel it): ______ Present moment: ______

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: ______________

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other: ______________________

What has helped/ provided most relief? ____________________________________

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Additional Concern 2 :____ How long have you experienced this?_____________________

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness

☐ Swelling ☐ Other:_____________________________ Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_________________________________ How often does the pain occur?_________________________

What activities make it worse?:_____________________________ Worse in the morning or evening? ___________________________________

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to lift object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/Off Chair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:____

Rate the severity of your pain at its worst (1- Least to 10-Severe): ________Least severe (when you feel it):________ Present moment:__________

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _________________

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:____

What has helped/ provided most relief?____

4 Family History

Please indicate if siblings, parents, or grandparents have a history of any of the following:

☐ Autoimmune Disease ☐ Cancer ☐ High Blood Pressure ☐ Osteoporosis

☐ Bleeding Disorder ☐ Diabetes ☐ Kidney Disease ☐ Stroke

☐ Clotting Disorder ☐ Heart Disease ☐ Migraines ☐ Thyroid Disease

☐ Family has no history of these conditions

5 Personal History

Please indicate if you have a history of the following:

☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Anxiety/Depression
☐ Appendicitis
☐ Arthritis (Osteo, Rheumatoid, etc.)
☐ Asthma
☐ Autoimmune Disorder
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer
☐ Chemical Dependence/Alcoholism
☐ Chicken Pox
☐ Clotting Disorder
☐ Patient has no history of these conditions

☐ Diabetes
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy/Seizure Disorder
☐ Headaches
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Migraines
☐ Mononucleosis

☐ MS
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's
☐ Pinched Nerve
☐ Pneumonia
☐ Prostate Problem
☐ Psychiatric Care
☐ STD
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers

Are you Pregnant? ☐ Yes ☐ No ☐ Does Not Apply How Many Weeks?______________

You certify that you are NOT pregnant, and that Chiro One's staff has your permission to perform an X-ray evaluation, if medically necessary. You have been advised that X-ray can be hazardous to an unborn child. Date of last Period: ____________________

Patient Signature:____ **Date:**____________________

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General PCP Name:____ Phone Number:____

Please enter the last known date and any notable findings:

Physical Exam:___________ Spinal X-Ray: ___________ Spinal Exam: ___________ Chest X-ray: ___________

MRI: ___________ CT-Scan: ___________ Bone Scan: ___________ Blood Test: ___________ Urine Test: ___________

Notable Findings:____

Are you taking any Medications?☐Yes☐No List/Frequency:____

____

Do you take any Vitamins or Supplements? ☐Yes☐No List/Frequency:____

____

Previous Chiropractic Experience?☐Yes☐No Last seen date/Describe: ____

6 Life Activities

Occupation:____ Employer/School:____

Primary Work Activities: ☐Sitting ☐Standing ☐Light labor/lifting ☐Heavy labor/lifting ☐Repetitive motions

Previous Work Injuries (Date/Description): ____

Marital Status ☐Married/Partnered ☐Single ☐Widowed

Emergency Contact Name:____________________________ Phone:________________________ Relationship to Patient: ____________________

Children Name/Age:____ Did you give birth? ☐Yes ☐No

Please describe any complications during pregnancy:____

Home Physical Activities:____

Home Injuries (Date/Description):____

Exercise:☐None☐Light☐Moderate☐Heavy Sport Activities (Prior/Current):____

Sport Injuries (Prior/Current): ____

Habits: ☐Nicotine☐Alcohol☐Coffee/Caffeine Drinks☐High Stress Level ☐None How Often:____________________________________

Sleep Hours/Night: ___________

Please rank how your time is spent/ Personal Values (1- Most/ 6- Least)

____Family/Home ____Career/Financial ____Social/Friends _____Mental Health/Spiritual _____Fitness/Nutrition ____Sleep/Rest

7 Prior Traumas

Have you ever been in a Motor Vehicle Accident? ☐Yes☐No

Date of Accident:_________ Symptoms/Pain:__________________________________ Treatment Received:☐Medical ☐Chiropractic ☐None

Details including speed of vehicle:____

____

Date of Accident:_________ Symptoms/Pain:__________________________________ Treatment Received:☐Medical ☐Chiropractic ☐None

Details including speed of vehicle:____

____

Falls (Date/Describe):____

Head Injuries (Date/Describe):____

Dislocations (Date/Describe):____

Broken Bones (Date/Describe):____

Surgeries (Date/Describe):____

8 Payment/Insurance Info

Who is financially responsible for this account? ☐Self ☐Other Name:____________________ Relationship to patient:__________________________

Is the patient covered by insurance? ☐Yes ☐No Name of Insurance Company:____

Who is the main/subscriber or policy holder? ☐Self ☐Other

Subscriber Name:_______________________________ Relationship to Patient:_________________ Subscriber Birth Date:_________________________

Is the policy associated with: ☐HSA ☐FSA ☐HRA ☐None

Is the patient covered by additional/secondary insurance? ☐Yes ☐No Name of Insurance Company:_______________________________________

Who is the main/subscriber or policy holder? ☐Self ☐Other

Subscriber Name:_______________________________ Relationship to Patient:_________________ Subscriber Birth Date:_________________________

9 Additional Clinical Comments

Clinical Comments: ____

Examiner's Name: ____ Examiner's Signature: ________________________Date: __________

Physician/Provider Name: __________________________ Physician/Provider Signature: _______________________ Date:__________