

## New Patient Intake Form

### PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### CHIEF COMPLAINT(S)

Mark all complaints and concerns that apply.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Frequent Fatigue   | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Unhappy with Weight | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Headache           | <input type="checkbox"/> Poor Memory         | <input type="checkbox"/> Ringing in Ears     | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Shoulder Pain       | <input type="checkbox"/> Joint Pain        |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Digestive Issues  |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Weakness          |

### CHECK AREAS OF PAIN OR WEAKNESS

- |   |   |                                       |                                    |
|---|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Neck R/L       | <input type="checkbox"/> Shoulder R/L | <input type="checkbox"/> Elbow R/L |
| <input type="checkbox"/> Hand/Wrist R/L | <input type="checkbox"/> Mid Back       | <input type="checkbox"/> Low Back     | <input type="checkbox"/> Hip R/L   |
| <input type="checkbox"/> Knee R/L       | <input type="checkbox"/> Foot/Ankle R/L | <input type="checkbox"/> Buttock R/L  | <input type="checkbox"/> Leg R/L   |

### PAIN DIAGRAM

What health condition(s) bring you into our office?

Mark the areas on the body where you feel pain or symptoms.

When did the condition first begin?

How did the problem start?

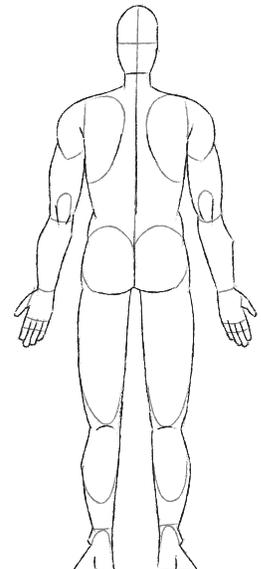
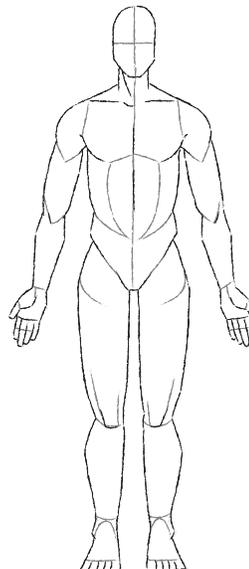
- Suddenly     Gradually     Post Injury

Is this condition?

- Getting Worse     Improving     Intermittent  
 Constant     Unsure

[ FRONT VIEW ]

[ BACK VIEW ]



## SYMPTOM ORDER

List your problems from most to least concerning:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PROVIDERS OR CLINICS YOU'VE SEEN

Primary Care: \_\_\_\_\_ Ever Seen? Y / N Last Date Seen: \_\_\_\_\_ City/State: \_\_\_\_\_  
Chiropractor: \_\_\_\_\_ Ever Seen? Y / N Last Date Seen: \_\_\_\_\_ City/State: \_\_\_\_\_  
Other: \_\_\_\_\_ Ever Seen? Y / N Last Date Seen: \_\_\_\_\_ City/State: \_\_\_\_\_

## PATIENT'S MEDICAL HISTORY

Have you been diagnosed, or suspect you have any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Stroke         | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Asthma         | <input type="checkbox"/> COPD             |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> Lupus            |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Depression     | <input type="checkbox"/> Anxiety          |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Other: _____     |

## SURGERIES, HOSPITALIZATIONS, ACCIDENTS, & SERIOUS ILLNESSES:

---

---

---

---

## CURRENT MEDICATIONS/ SUPPLEMENTS & ALLERGIES :

---

---

---

---

## SOCIAL / LIFESTYLE / OCCUPATIONAL FACTORS

Current or Former Smoker?  Y  N Describe Frequency: \_\_\_\_\_  
Do you drink Alcohol?  Y  N Describe Frequency: \_\_\_\_\_  
Drink Caffeinated Beverages?  Y  N Describe Frequency: \_\_\_\_\_  
Recreational Drug Use?  Y  N Describe Frequency: \_\_\_\_\_  
Exercise?  Y  N Describe Frequency: \_\_\_\_\_  
Are you Pregnant?  Y  N Date of Last Period: \_\_\_\_\_  
Occupational History: \_\_\_\_\_