General Patient Intake Form

Smith Chiropractic
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Patient Information:

Full Name_____ Nickname:_____ Date: _____

Email_____ Gender ___M ___F DOB_____ HT___'___" WT_____lbs.

Address_____City_____State_____Zip_____

Home Phone (_____)_____ Cell phone (_____)_____ Work phone (_____)_____

Marital Status: ___ S ____ M ____ D ____ W # of children _____ Social Security #_____

Employer _____ Occupation _____ Work Status: ____ FT ____ PT____ Retired

Employer Address _____ City _____ST_____ Zip_____

Name of Spouse, Parent or Guardian_____ Age_____ Birth Date_____

Spouse's Employer_____ Spouse's Occupation_____ Wk Phone_____

Emergency Contact_____Relationship_____Phone _____

How did you hear about our office? _____

Insurance Information:

Insurance Carrier _____ Primary Insured _____

Insured's Date of Birth _____ Insurance Policy ID _____ Group # _____

Relationship to Patient ____ *Self* ____ *Spouse* ____ *Parent* ____*Other* Patient is ____ *Full time student* ____ *Part time student*

Is the condition related to ____ *Auto Injury* ____ *Work Injury* ____ *Other Injury*

Do you have secondary insurance coverage ____ *Y* _____ *N* Insurance Company Name _____

Insured's Name _____ Insured's Date of Birth _____ SS#_____

Policy ID _____ Group Number _____ Phone (_____)_____

Patient Health History:

ALLERGIES: *Please check and list all allergies*

___ *Food* _____

___ *Medications* _____

___ *Seasonal / Other*_____

MEDICATIONS: *Please list all medications that you are currently taking* _____

_____

SUPPLEMENTS: *Do you take Vitamins or Herbs?* ___ *Y* ___ *N* Who recommended them?_____

List supplements/herbs that you take _____

_____

HABITS: Heavy Moderate Light None

Alcohol _____ _____ _____ _____

Coffee _____ _____ _____ _____

Soda _____ _____ _____ _____

Tobacco ____ _____ _____ _____

Drugs ____ _____ _____ _____

Exercise ____ *5-7x/wk* ____ *3-5x/wk* ____*1-3/xwk* ____ *None*

Sleep ____ *8+ hrs* ____ *7-8 hrs* ____ *6-7 hrs* ____ *< 5 hrs*

Meals / Day ____ *5+* ____ *4* ____ *3* ____ *2* ____*1*

Stress Level ____ *High* _____ *Moderate* ____ *Low* ____*What Stress*

Water / day ____ *64+ oz* ____ *23-63 oz* ____*16-32 oz* ____*<8 oz*

Work Activity: ____*Heavy Labor* ____*Light Labor* ____*Mostly Sitting* ____*Mostly Standing* ____ *Walking/ Moving*

Current Condition:

Complaint/Problem: _____

When did you first notice this problem? List date when first occured_____

How did it originally occur?_____ Has it changed recently? ____Y ____N ____Same ____ Better ____ Worse

Has another doctor(s) treated you for this condition ____ Y ____ N *If yes, when*_____

Previous Treatment _____

Have you had any intolerance or reactions to treatments? ____Y ____N *Describe:*_____

How frequent is the condition? ____ *Constant* ____ *Daily* ____ *Intermittent* ____*Night only* ____*Activity Induced*

How long does it last? ____*Constant* ____ *Few hours* ____ *Few Minutes*

Is this condition interfering with your ____*Work* ____*Sleep* ____*Daily routine* ____*Recreation*

How long has it been since you really felt good? ____*Days* ____*Weeks* ____*Months* ____*Years* ____*>10 years*

Describe the pain: ____*Sharp* ____ *Dull* ____ *Numb* ____*Tingling* ____ *Aching* ____ *Burning* ____*Stabbing*

What makes the problem worse? ____*Standing* ____ *Sitting* ____ *Lying* ____*Bending* ____*Lifting* ____*Twisting*

Is there anything that you can do to relieve the problem? ____ Y ____ N *If yes, describe*_____

If no, what have you tried to do that has not helped? _____

Are there any other conditions or symptoms that may be related to your major symptom? ____ Y ____ N

If yes, what? _____

Have you ever been in an auto accident? ____ *Past year* ____ *Past 5 years* ____ *Over 5 years* ____ *Never*

*Describe*_____

Please mark all of the symptoms that apply with a P or C (P = Past / C=Current)

___*Tingling*	___*Nausea*	___ *Weak Muscles*	___*Dizziness*	___*Excessive Thirst*	___*Frequent Urination*
___*Insomnia*	___*Sinusitis*	___*Constipation*	___*Sore Muscles*	___*Teeth Grinding*	___*Low Back Pain*
___*Fatigue*	___*Neck Pain*	___*Blurred Vision*	___ *Facial Pain*	___*Carpal Tunnel*	___*Jaw Problems*
___*Earache*	___*Hip Pain*	___*Joint Stiffness*	___*Shoulder Pain*	___*Elbow/Hand Pain*	___*Tension*
___*Headache*	___*Knee Pain*	___*Swollen Joints*	___*Ankle/Foot Pain*	___*Abdominal Pain*	____*Memory Loss*
___*Fainting*	___*Eye Pain*	___*Tingling in Feet*	___ *Other:* _____		

Family History: Identify any conditions that you, or any of your family members have or had in the past:

(G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

_____ Alcoholism	_____Eczema	_____Miscarriage(s)	_____Tumor(s)
_____Anemia	_____Emphysema	_____Mumps	_____Ulcer(s)
_____Asthma	_____Epilepsy	_____Pleurisy	_____Other:_____
_____Cancer	_____ Heart Disease	_____Stroke	_____
_____Chemotherapy	_____HIV/AIDS	_____Psychiatric Problems	
_____Cold Sores	_____Headaches	_____Rheumatic Fever	
_____Diabetes	_____Sinus Problems	_____High/Low Blood Pressure	

Patient Signature_____ **Date** _____