



PATIENT INTAKE FORM FOR AFFINITY CHIROPRACTIC

Today's Date: _____
 Name: _____ How would you like to be addressed? _____
 Date of Birth: _____ Age: _____ Gender: _____
 Address: _____
 City: _____ State: _____ Zip: _____

SS#: _____ Marital Status: S M W D Email Address: _____
 Wrk:(_____) Hme #: (_____) Cell#:(_____)

Your Occupation: _____
 Your Emergency Contact: _____ Phone #: (_____)

How Many Children Do You Have? _____ What Are They're Ages: _____
 Do They Or Other Members Of Your Family Receive Chiropractic Care? es No

Have You Ever Had Chiropractic Care? Yes No How Long Has It Been? _____

What Is The Reason For Today's Appointment? _____

Have You Ever Had Chiropractic Care? Yes No How Long Has It Been? _____

How Often Do You Drink Alcoholic Beverages? _____

Do You Smoke? Yes No How Much? _____

Do You Exercise? Yes No How Often? _____ Type? _____

Do You Have Any Allergies (please specify): _____

Have You Ever Suffered From or Been Diagnosed As Having: (circle yes or no)

- | | |
|--------------------------------|-----------------------------|
| Y N A Congenital Disease | Y N Gall Bladder |
| Y N Alcoholism | Y N * Head Problems |
| Y N *Broken or Fractured Bones | Y N High/Low Blood Pressure |
| Y N *Cancer | Y N HIV |
| Y N Coughing Blood | Y N *Osteoarthritis |
| Y N Depression | Y N Pacemaker |
| Y N *Diabetes | Y N *Rheumatoid Arthritis |
| Y N Drug Addition | Y N *Ruptures |
| Y N Eating Disorder | Y N Seizures/Convulsions |
| Y N Epilepsy | Y N Strokes |
| Y N Excessive Bleeding | Y N Tumors |
| Y N Gall Bladder | Y N Ulcers |

* Explanation: _____

When Was Your Last Physical Exam _____

When Was The Last Time You Were Involved In An Accident Of **ANY** Kind? _____

MEDICATION / VITAMIN LIST (please list all within the last 2 years)

| Name Of Medication Or Vitamin | Date Started | Date Stopped | Dosage | Who Prescribed? | |
|-------------------------------|--------------|--------------|--------|-----------------|------|
| | | | | DR | SELF |
| | | | | D | S |
| | | | | D | S |
| | | | | D | S |
| | | | | D | S |
| | | | | D | S |

FOR DOCTOR'S USE ONLY

General

Injury Type: _____

NDRA

Drug Allergies: _____

Meds Addendum

(use next page if necessary)

Date: _____

Patient: _____

Systems Review

In the left hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had In the Past. If neither apply, mark (NA). Don't leave any blanks.

- High Blood Pressure _____
- Dizziness/Fainting _____
- Insomnia _____
- Tension _____
- Confusion _____
- Fatigue _____
- Ulcers _____
- Eye/Vision Problems _____
- Ear/Hearing Problems _____
- Difficulty Breathing _____
- Heart Problems _____
- Loss of Bladder Control _____
- Constipation _____
- Diarrhea _____
- Digestion Problems _____
- Nausea _____
- Female Problems _____
- Prostate Problems _____
- Diabetes _____
- Cold Hands/Feet _____
- Hand Tremors _____
- Loss of Memory _____
- Nervousness _____
- Sweaty Palms _____
- Speech Difficulty _____
- Anxiety _____
- Depression _____
- Irritability _____

| For Doctor's Use Only | |
|------------------------------|---|
| General | Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity |
| Skin | Rashes, eruptions, bruising, itching, hair loss, changes in warts, moles, or nails. |
| Head | Trauma, headaches, dizziness, lightheaded |
| Eyes | Change in acuity, blurred vision, double vision, pain, excessive lacrimation, redness |
| Nose | Rhinorrhea, epistaxis, allergies, airway obst. |
| Lungs | Cough (productive/nonproductive), dyspnea, pain w/respiration, wheezing, night sweats |
| Cardiac | Palpitations, chest pain, orthopnea ankle swelling, syncope |
| Vascular | Raynaud's Phenomenon, hypertension intermittent claudication, rhuematic fever |
| Breasts | Pain, nipple discharge, lumps, masses, skin dimpling, self examination freq. |
| GI | unusual diet, nausea, vomiting, pain, diarrhea, constip, swelling, hematemesis |
| GU | Polyuria, nocturia, oliguria, dysuria, hernia incontinence, dyspareunia, color changed |
| Endocrine | polydypsia, polyphagia, tremors, goiter alopecia, menstruation, dysmenhorrea |
| Musculo | Bone/joint pain, swelling, deformity, trauma dec. ROM, weakness, atrophy |
| Neuro | Cranial nerve deficits, seizures, LOC, tremors, staxis, loss of balance, paresthesia |
| Psych | mood swings, depression, anxiety, phobias. |

Please identify all facilities/providers you have seen for these conditions and those are currently seeing, if any, for your presenting problem(s)

Problem List

| Dr Name/Facility | Problem | Type of treatment received | Dates of treatment |
|------------------|---------|----------------------------|--------------------|
| | | | |
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| For Doctor's Use Only | |
|--|-----|
| <input type="checkbox"/> Reviewed External | H P |
| <input type="checkbox"/> Release Records | H P |
| <input type="checkbox"/> Request Records | H P |
| External Dx'd: _____ | |
| Disabilities: _____ | |
| Impairments: _____ | |

Date: _____ Patient Name: _____

Patient History

1. What is your main complaint? _____

2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

| | | | | | | | | | |
|-------------|---------------|----------|-------------|----------|-----------------|----------|---------------|----------|-----------|
| None | Slight | | Mild | | Moderate | | Severe | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

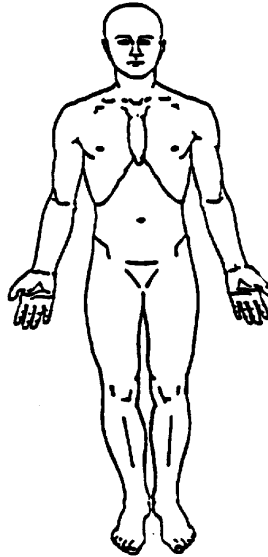
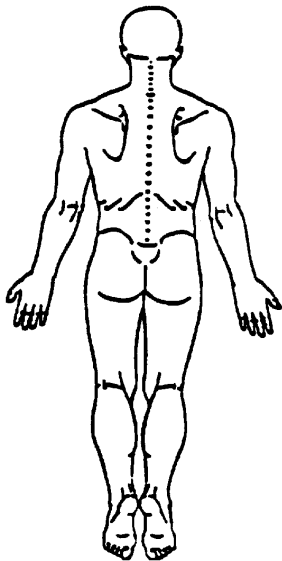
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

| | | | | | | | | | |
|-----------|-------------------|-----------|---------------------|-----------|-----------------|-----------|-----------------|-----------|------------|
| | Occasional | | Intermittent | | Frequent | | Constant | | |
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

4. How **long** have you been experiencing your **main complaint**? _____

5. On the following diagram below, please show **where** you are experiencing **all** of your present symptoms using the following letters:

A: Ache **B:** Burning pain **C:** Cramping **D:** Dull pain **R:** throbbing pain **N:** Numbness **T:** Tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

Personal care _____
Lifting _____
Reading _____
Concentrating _____
Work _____
Driving _____
Sleeping _____
Recreation _____
Walking _____
Sitting _____
Standing _____
Social life _____

6. When do you notice it most? _____ **AM** _____ **PM**

How long does it last? _____ mins _____ Hrs

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? _____ yes _____ no

10. What treatment have you received in the past for this problem? _____

11. Have you lost work from it? _____ Yes _____ No

Dates: From _____ to _____

12. Are you pregnant? _____ Yes _____ No

13. What was the first day of your last menstrual cycle? _____

14. Number of Pregnancies? _____ miscarriages? _____

Signature: _____

Date: ____ / ____ / ____