

ALLEN CHIROPRACTIC INTAKE FORM

Name: _____
Address: _____
Home: _____ - _____ - _____ Work: _____ - _____ - _____ Cell: _____ - _____ - _____
Email Address: _____ Occupation: _____
Date of Birth: _____ Social Security #: _____ - _____ - _____ Marital Status: _____
Gender: M F Spouse's Name: _____ Spouse's cell: _____ - _____ - _____
Emergency Contact (EC): _____ EC's Phone: _____ - _____ - _____

Allergies: (Please Circle and or fill in all that apply)

Animals Aspirin Bee Stings Cats Chocolate Dairy Products Dust Eggs Iodine Latex Molds Penicillin Ragweed/Pollen
Rubber Seasonal Allergies Shellfish Smoke Soaps Wheat X-Ray Dye Medications: _____
Other: _____ I am not allergic to anything

Surgeries: (Please list approximate date of procedure and give brief details)

1. ___/___/___ _____
2. ___/___/___ _____
3. ___/___/___ _____
4. ___/___/___ _____

Medical History: (Please Circle and or fill in all CURRENT & PAST medical conditions)

AIDS/HIV Alcoholism Anemia Anxiety Appendicitis Arthritis Asthma Bleeding Disorder Broken Bones Bronchitis Cancer
Chemical Dependency Chest Pain Depression Diabetes Dizziness Eczema Epilepsy Eye/Vision Problems Fainting Fatigue
Fibroids Goiter Gout Headaches Heart Disease Hearing Problems Hepatitis Hernia (abdominal or Groin) Herniated Disc
Herpes (oral or genital) High Blood Pressure High Cholesterol Hip Pain Jaw Pain Kidney Disease Kidney Stones Knee Pain
Leg Pain Liver Disease Low Back Pain Menstrual Problems Mid-Back Pain Migraine Headaches Miscarriage Mononucleosis
Multiple Sclerosis Neck Pain Neurological Problems Osteoarthritis Osteoporosis Pacemaker Parkinson's Pinched Nerve Polio
Prostate Problems Prosthesis Psychiatric Care Rheumatoid Arthritis Rheumatic Fever Scarlet Fever Scoliosis Shoulder Pain
Significant Weight Change Sinus Problems Sleep Apnea Spinal Cord Injury Stroke/Heart Attack Stomach or Digestive Problems Suicide
Attempt Thyroid Problem Tonsillitis Tuberculosis Ulcers Other: _____

Medication: (Please Circle and or fill in all that apply)

Anxiety Muscle Relaxers Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
Other: _____

Family History: (Please Circle and or fill in all that apply)

1. Family Member: _____ Condition(s): _____
2. Family Member: _____ Condition(s): _____
3. Family Member: _____ Condition(s): _____
4. Family Member: _____ Condition(s): _____

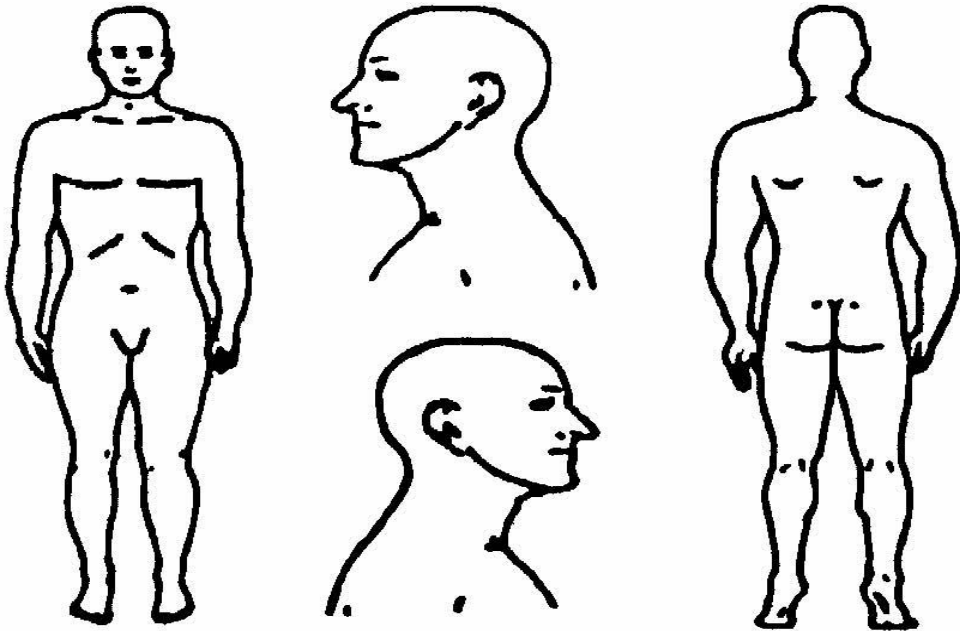
Date of last physical examination: ___/___/___ Primary Doctor: _____
Do you smoke _____ Do you drink alcohol _____ Cups/day _____ Do you drink caffeine _____ Cups/day _____
Do you exercise? No Yes (what forms and how often): _____

What is your main reason(s) for consulting this office? (Circle all that apply)

Become pain free Explanation of my condition Learn how to care for my condition Reduce symptoms
Resume normal activity level

What was your weight at the last time you checked? _____ lbs What is your height? _____ ft _____ inches

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



What is your major complaint? _____ Date problem began? __/__/____
How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms? (Circle what applies)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe this symptom: (Circle all that apply)

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) _____

What activities aggravate your condition _____

What makes your pain better _____

What is your second complaint? _____ Date problem began? __/__/____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms? (Circle what applies)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe this symptom: (Circle all that apply)

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) _____

What activities aggravate your condition _____

What makes your pain better _____

What is your third complaint? _____ Date problem began? __/__/____ How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms? (Circle what applies)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe this symptom: (Circle all that apply)

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) _____

What activities aggravate your condition _____

What makes your pain better _____

What is your fourth complaint? _____ Date problem began? __/__/____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms? (Circle what applies)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe this symptom: (Circle all that apply)

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) _____

What activities aggravate your condition _____

What makes your pain better _____

Please list any additional information that you feel is important for us to know.

With my signature I certify that all of the above is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____