PATIENT INTAKE FORM
PLEASE TELL US ABOUT YOU

Today's Date ____/___/ ____ **Patient #_____**

Full Legal Name _____

Male __ Female __ Single___ Married___ Widow___ Divorced___ Spouse or Partners name_____

How you prefer to be addressed _____ Birthdate _____/_____/_____ Age_____

E-mail address_____ would you like to be emailed about updates and specials?_____

Street Address _____ Home Phone ____-____-_____

City _____ State _____ Zip Code _____

Retired ___ what type of work did you perform?_____ Cell Phone _____-_____-_____

Employer's Name _____ What do you do there? _____

Referred to our office by _____

In Case of Emergency Contact _____ Phone # ____-_____-_____ Relationship _____

Is your current condition the result of an accident/injury? Yes __ No ___ If yes: Auto __ Work __ Slip/Fall __

***Attention Medicare patients: We do not participate or take assignment with Medicare. We are required to bill Medicare for your treatment and they may reimburse you directly. Medicare will forward these covered charges to your secondary insurance. Please note we are not in network with any Medicare Advantage Plans. Payment is due at the time of service.**

What are you current symptoms? 1. _____ 2. _____
3. _____ 4. _____

What level of intensity would you rate your pain? (10=severe) ***1 2 3 4 5 6 7 8 9 10***

What is the frequency of your symptoms? ***Occasional / Episodic / Intermittent / Frequent / Constant***

Do your symptoms affect your personal life or job ? (sleep, hobbies, sports, missed days, inability to stand, sit, lift, drive)

_____

_____

_____

When was the onset of your symptoms or condidtion? _____

Have you suffered from these symptoms before? □ Yes □ No

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you been to any other type of doctor for this problem? _____

Have you been to a Chiropractor before? □ Yes □ No If Yes, Who?_____

Did prior chiropractic treatment help your problem?_____

Who is your primary care physician?_____

Please check the appropriate box(es) for any of the following symptoms of ill health which you may now have or have had previously. In order to provide necessary chiropractic care we need to know all the facts related to your health. This is a Confidential Health Report.

- ☐ Headaches
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Pins + Needles in Arms
- ☐ Pins + Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Pain in the Arms
- ☐ Pain in the Legs
- ☐ Pain between Shoulders
- ☐ Hands Cold
- ☐ Feet Cold
- ☐ Neck Stiff
- ☐ Back Stiff
- ☐ Convulsions
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Eyes Sensitive to Light
- ☐ Loss of Memory
- ☐ Ringing in the Ears
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Poor Digestion
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Shortness of Breath
- ☐ Chronic Cough

Have you ever?

Yes	No	
☐	☐	Been Knocked Unconscious?
☐	☐	Used Crutches or other Support?
☐	☐	Been Treated for Spine Problems?
☐	☐	Been Treated for any Nerve Disorder?
☐	☐	Had a Fractured/Broken Bone?
☐	☐	Had Surgery?
☐	☐	Been Hospitalized for Other than Surgery?

Habits:

Have you in the past or do you currently use:

- ☐ Alcohol If yes how often? _____
- ☐ Coffee How many cups per day?_____
- ☐ Tobacco How many pack per day? _____
- ☐ Medical Marijuana? _____

Please list current medications and

Nutritional supplements you are taking or

Provide list to the doctor

_____

_____

_____

_____

_____

_____

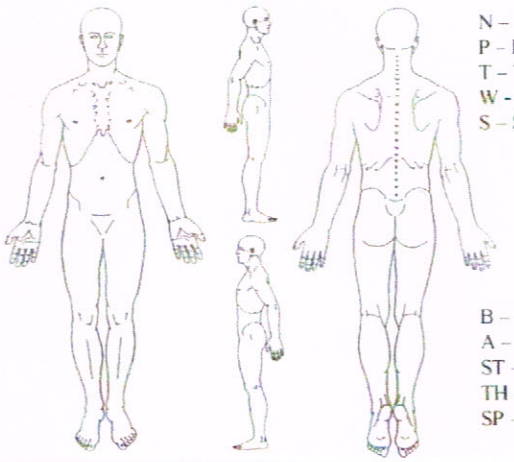
Date of Last : (approximate)

- _____ Physical Examination
- _____ Blood Test
- _____ Urine Test
- _____ Chest X-ray
- _____ Spine X-ray
- _____ Dental X-ray
- _____ Other
- _____ Do you have a Pace Maker/Defibrillator

Is there a Family History of?

- ☐ Heart Disease ☐ Arthritis
- ☐ Cancer ☐ Diabetes
- ☐ Stroke ☐ _____

Please mark the area & type of pain on the drawings using the code listed below.



N – Numbness
P – Pain (Sharp/Stabbing)
T – Tingling
W - Weakness
S – Soreness

B – Burning
A – Ache
ST – Stiffness
TH – Throbbing
SP – Spasm/Cramping

Patient Acknowledgement

By my signature, I understand and acknowledge that Shanlyn M. Newman D.C., will treat my condition as deemed necessary through the use of Chiropractic Manipulative Therapy and adjunctive therapies. I also understand that all original documents and original x-rays created as a result of the performance of examinations will remain the property of Newman Chiropractic, who will not be held responsible for any undisclosed pre-existing conditions. As the parent, guardian or parentally authorized agent, I hereby authorize Shanlyn M. Newman D.C., to administer care to this minor. After completing this questionnaire your signature will verify that all information you have given is to accurate to the best of your knowledge.

Signed: _____ **Date:** _____