

# NEW PATIENT INTAKE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

We use text messaging for appointment reminders. Who is your cell phone company? \_\_\_\_\_

Email Address: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Have you seen a Chiropractor before? Yes No If yes, when? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## YOUR HEALTH SUMMARY

Please  check all symptoms you have ever had, even if they do not seem related to your current problem.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck stiff               | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Cold sweats              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Problem urinating      | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers          |

List any medications you are taking \_\_\_\_\_

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: \_\_\_\_\_.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

## 1. Pain Intensity

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No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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## 6. Recreation

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No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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## 2. Sleeping

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Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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## 7. Frequency of Pain

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No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
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## 3. Personal Care (washing, dressing, etc.)

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No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
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## 8. Lifting

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No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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## 4. Travel (driving, etc.)

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No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
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## 9. Walking

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No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
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## 5. Work

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Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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## 10. Standing

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No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing
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Name \_\_\_\_\_ Total Score \_\_\_\_\_

PRINTED

Signature \_\_\_\_\_

Date \_\_\_\_\_