Patient Name: _____

360 CHIROPRACTIC, P.S.

CHIROPRACTIC I MASSAGE I LL LASER THERAPY

Patient Intake Form

DEMOGRAPHICS

Legal Name: _____ DOB: ___/___/____ Age: _____ ☐ Male ☐ Female
Address: _____ APT# _____ SSN: _____ - _____ - _____
City: _____ State: _____ ZIP Code: _____ Home Phone:(____) _____
Cell Phone: (_____) _____ Email: _____
Which method is the best to reach you? ☐ Cell ☐ Home ☐ Email ☐ Work
Receive appointment reminders: ☐ Text ☐ Voice ☐ Email ☐ Decline
Marital Status: ☐ Single ☐ Married ☐ Other
Job Status: ☐ Not Employed ☐ Employed ☐ Retired ☐ Part- Time Student ☐ Full- Time Student
Employer's Name: _____ Occupation: _____
Race: ☐ White ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other_____ ☐ I choose not to specify
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ I choose not to specify
Preferred Language: _____
Do you smoke?
Smoking (Packs per day) ..... ☐ Never ☐<1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about us?: ☐ Friend:_____ ☐ Relative:_____ ☐ Internet ☐ Other

CURRENT CLAIM INFORMATION

Is your complaints do to any of the following: ☐ Auto Accident ☐ Work Injury
I have opened a claim: ☐ Yes ☐ No What was your date of injury?: _____/_____/_____
Claim number: _____

INSURANCE INFORMATION (IF APPICABLE)

Insureds First Name: _____ Insureds Last Name: _____
Insureds DOB: _____
Insurance Name: _____ ID/Policy#: _____
Group#: _____

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

Patient Name: _____

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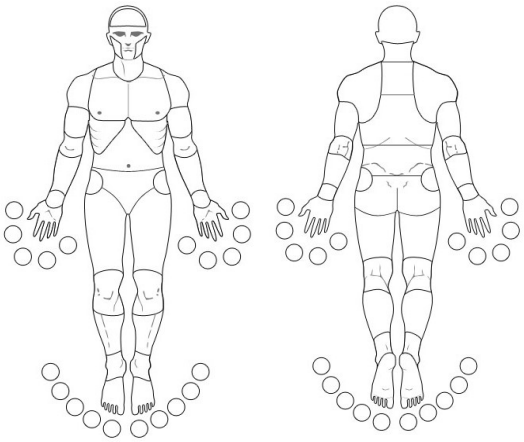
COMPLAINTS

1. Please shade in the area on the diagram where you are experiencing pain or other symptoms.



2. List your complaints in order of most to least pain along with the pain rating. **(0-10 with 0 being no pain and 10 being the worst pain imaginable)**

A. _____

B. _____

C. _____

D. _____

Date Symptoms Began: _____

Description of pain: (label which complaint has this description)

☐ Aching ☐ Burning ☐ Cramping ☐ Deep ☐ Dull ☐ Numbness ☐ Radiating ☐ Sharp

☐ Shooting ☐ Stabbing ☐ Swelling ☐ Tenderness ☐ Tight ☐ Throbbing ☐ Weakness ☐ Other:

Frequency:

☐ Constant (100%-75%): _____

☐ Frequent (75%-51%): _____

☐ Intermittent (50%-26%): _____

☐ Occasional (25% or less): _____

What makes your symptoms worse?

☐ Nothing ☐ Bending ☐ Coughing ☐ Exercise ☐ Reaching ☐ House chores ☐ Lifting

☐ Looking up/down ☐ Sleeping/Lying ☐ Sneezing ☐ Sitting ☐ Standing ☐ Stairs ☐ Straining at stool

☐ Twisting ☐ Turning ☐ Walking ☐ Other: _____

What makes your condition better?

☐ Nothing ☐ Exercise ☐ Heat ☐ Ice ☐ Massage ☐ Medication ☐ Standing/Sitting ☐ Rest

☐ Other: _____

Have you had chiropractic treatment before: ☐ Yes ☐ No

Patient Name: _____

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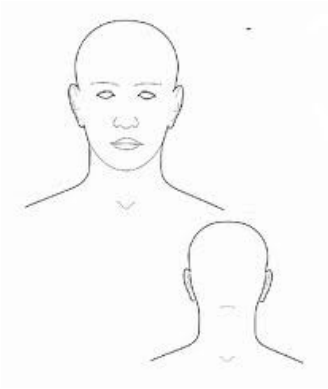
Do you suffer from Headaches? Yes/ No (if yes, please complete the headache section)

Shade the area of Headaches when occur.



1. On what date did your headaches begin?
Date: _____ ☐ Same date as other symptoms
☐ Gradually ☐ Sudden

2. Description of Headache Pain:
☐ Dull ☐ Deep ☐ Aching
☐ Sharp ☐ Vice-like ☐ Burning
☐ Stabbing ☐ Throbbing/Pulsating
☐ Other _____

3. When do your headaches usually start?
☐ Constant/Anytime awake
☐ Wake up with in the morning
☐ At midday
☐ During the evening

4. What seems to bring on your headaches?
☐ Physical activity ☐ Caffeine ☐ Certain foods
☐ Menstrual Period ☐ Excessive Stress
☐ Other: _____

5. How often do your headaches occur:
☐ _____ times per week
☐ _____ times per month
☐ Other:_____

6. How long do your headaches last?
☐ Less than 1 hour ☐ From 1-3 hours
☐ Longer than 3 hrs ☐ Several hours to days
☐ Other: _____

7. Do any of the following occur with your headaches?
☐ Weakness ☐ Dizziness
☐ Tremor ☐ Light/Sound sensitivity
☐ Vision problems ☐ Other: _____

8. What makes your headaches better?
☐ Nothing ☐ Rest ☐ Lying down
☐ Massage ☐ Ice/Cold packs ☐ Standing
☐ NSAIDS (Aspirin, Tylenol, etc.) ☐ Chiropractic
☐ Other: _____

9. Do your headaches wake you from sleep?
☐ No ☐ Sometimes ☐ Always

10. Have you ever suffered a concussion? Yes/ No (If so how many?)_____

HEALTH HISTORY

Medications (+ Dosage) / Vitamins/ Minerals:

Allergies (Medication, Food, Environmental):

Surgeries/ Hospitalizations/ Traumas (Include Date):

REVIEW OF SYSTEMS

☐ **None of the symptoms listed below**

☐ General fatigue/weakness	☐ Hay Fever	☐ Asthma
☐ Nose/sinus pain/Pressure	☐ Nose Bleeds (chronic)	☐ Nasal Discharge
☐ Decreased Hearing	☐ Earache	☐ Ear infections
☐ Ringing in Ears	☐ Poor Balance	☐ Dizziness/ Fainting
☐ Sore Throat	☐ Difficulty Swallowing	☐ Dry Mouth
☐ Frequent Urination	☐ Difficulty Urinating/Pain	☐ Kidney Stones
☐ Diabetes: Type I or II	☐ Kidney Infections	☐ Prostate trouble
☐ Change in Appetite	☐ Change in bowel or bladder	☐ Constipation
☐ Diarrhea	☐ Nausea	☐ Abdominal Pain
☐ Heat/Cold Intolerance	☐ Night Sweats	☐ Excessive Thirst
☐ Bruise Easily	☐ Swollen extremities	☐ Leg Cramping
☐ Rapid heartbeat	☐ Chest pain	☐ Heart palpitations
☐ Heart murmur	☐ Anxiety	☐ Depression
☐ Memory Loss	☐ Nervousness	☐ Stress

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Other Symptoms/ Diagnosis/ or Complaints not listed:

_____
_____
_____
_____
_____
_____

Female: Please fill in all that apply:

Are you pregnant? Circle: Yes No

Number of pregnancies: _____

Number of Deliveries: _____

Patient Name Printed: _____

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____