



## Initial Intake Form

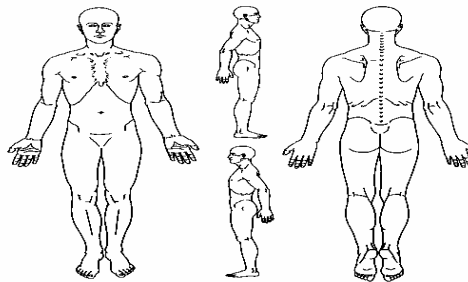
Last name: \_\_\_\_\_ First name: \_\_\_\_\_ SS# \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Age: \_\_\_\_\_  Male  Female Date of birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Current weight: \_\_\_\_\_ Height: \_\_\_\_\_ foot \_\_\_\_\_  
 Marital status: M S D W Spouse's name: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Person to be notified in case of an emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone number: \_\_\_\_\_  
 Who may we thank for referring you: \_\_\_\_\_

Present complaint: \_\_\_\_\_  
 Briefly describe how your problem began: \_\_\_\_\_  
 \_\_\_\_\_  
 When did the problem begin: \_\_\_\_\_  
 Did you have a similar problem in the past? \_\_\_\_\_  
 What activities aggravate your condition? \_\_\_\_\_  
 Is this condition getting progressively worse?  Yes  No  Constant  Comes & Goes  
 Is this condition interfering with your:  Work  Sleep  Daily Routine  Other \_\_\_\_\_  
 Other Doctors that treated this condition \_\_\_\_\_

Please locate and mark the quality of your pain on the body outlines below.

**Pain drawing key**

A=Ache  
 N=Numbness  
 B= Burning  
 S=Sharp shooting  
 P=Pins/ needles  
 O=Other



No pain \_\_\_\_\_ Worst pain

(please mark your level of pain)

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**Please check any of the following conditions that apply to you:**

<b><u>General</u></b>	<input type="checkbox"/> Blood in urine	<b><u>Head</u></b>	<b><u>Chest</u></b>
<input type="checkbox"/> Weakness	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Headaches	<input type="checkbox"/> COPD
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Fever	<input type="checkbox"/> Numbness legs or feet	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Fainting	<input type="checkbox"/> Tension	<input type="checkbox"/> Seizures/ convulsions	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Nausea	<input type="checkbox"/> Sleeping problems	<b><u>Eyes</u></b>	<input type="checkbox"/> Cold extremities
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Double vision	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Balance problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Eyes sensitive to light	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Leg pain	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Tooth pain	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> corrective lenses	<input type="checkbox"/> Ever had tuberculosis
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Abdominal pain	<b><u>Ears</u></b>	<input type="checkbox"/> Ever had pneumonia
<input type="checkbox"/> Arm pain	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Loss of hearing	
<input type="checkbox"/> Wrist/hand pain	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Ear infections	
<input type="checkbox"/> Hip pain	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Discharge from ear	
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Ringing/buzzing in ears	
<input type="checkbox"/> Numbness arms or legs	<input type="checkbox"/> Depression		
<input type="checkbox"/> Ankle/foot pain	<input type="checkbox"/> Cancer (type)_____		
<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Ankle/foot pain		
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Loss of bowel/ bladder control	

<b><u>MALE ONLY</u></b>	<b><u>FEMALE ONLY</u></b>
<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Hernias	<input type="checkbox"/> PMS
<input type="checkbox"/> STD'S	<input type="checkbox"/> Currently pregnant
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Testicular pain	<input type="checkbox"/> STD'S
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Menopause
<input type="checkbox"/> Painful erection	<input type="checkbox"/> Last pelvic exam_____
<input type="checkbox"/> PSA Test, if yes: results_____	<input type="checkbox"/> Last breast exam _____
	<input type="checkbox"/> Last pap smear _____
	<input type="checkbox"/> Date of last menstrual period _____

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I have been informed of the nature of my disorder(s) and the nature and purpose of chiropractic procedure and related therapeutics proposed as treatment. I have also informed of the possible consequences and risks inherent in such treatment. The availability of alternative treatment options has been explained to me. I have been also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for ant specific result.

**I HAVE READ THE ABOVE PARAGRAPHS AND I UNDERSATND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.**

**I THEREFORE AUTHORIZE SPINOUS TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.**

**PATIENT NAME** (PLEASE PRINT) \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

### When the patient is a minor or unable to consent

Patient is a minor of \_\_\_\_\_ years of age.  Other \_\_\_\_\_

**PATIENT NAME**( PLEASE PRINT) \_\_\_\_\_

**NAME OF PERSON LEGALLY AUTHORIZED TO SIGN FOR THE PATIENT:**

**AUTHORIZED PERSON** (PLEASE PRINT) \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_

**AUTHORIZED SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_