ReAlign
SPINE CHIROPRACTIC CARE

Date: _____

NEW PATIENT INTAKE FORM

Name: _____ Age: _____ Gender: M F

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____ / _____ / _____

Marital Status (circle) Single Married Divorced Widow Number of Children _____

Occupation: _____ Employer Name: _____

How did you hear about our office _____

Emergency Contact: _____ Relation to Patient: _____

Contact Phone: _____

PURPOSE OF THIS VISIT

- Main Complaint: _____ When did this condition begin? _____
- Have you had it before: ___ Yes ___ No Is this condition getting worse ___ Yes ___ NO
- On a scale from 0-10, how would you rate your pain at its' worst? (Circle one)

  No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
- Was there anything that happened specifically to make this complaint start? ❑ Yes ❑ No

  If yes, explain: _____
- Does your pain travel anywhere else on your body? ❑ Head ❑ Shoulders ❑ Arms ❑ Hands ❑ Buttocks ❑ Leg ❑ Feet ❑ Other: _____
- What does your pain feel like? ❑ Sharp/Shooting ❑ Numbness/Tingling ❑ Dull/Achy ❑ Burning
- Nature of Pain: ❑Constant ❑Frequent ❑Intermittent ❑Episodic
- Are there any activities or positions that make your pain WORSE? _____
- Are there any activities or positions that make your pain BETTER? _____
- Does your pain interfere with: ❑Work ❑Sleep ❑Recreation Activities of Daily Living ❑Other _____

- Have you seen any other provider or received any treatment for this condition? ❑ Yes ❑ No

  If yes, explain _____

- Is the condition (circle) Job related Auto Accident Work Accident Fall

  Date of Accident: _____

- Are there any other conditions or areas of concern that you would like us to look at?

  _____

- List any supplements you are currently taking _____
- List any medications you are currently taking _____
- List any surgeries you have had _____
- List any accidents/injuries/broken bones _____
- Have you been to a chiropractor before _____ Where _____ Last visit _____

HEALTH LIFESTYLE

- Do you exercise _____ Yes _____ No How often? _____ What activities? _____
- Do you smoke? _____ Yes _____ No How many cigarettes/packs per day / week _____
- Do you drink alcohol? ____ Yes ____ No How much / week? _____

FAMILY HEALTH HISTORY

Have any of your biological family members ever been diagnosed with the following:

____ Cancer ____ High Blood Pressure ____ Diabetes ____ Heart Problem ____ Stroke ____ Kidney Disease

____ Liver Disease ____ Autoimmune Disorder ____ Neurological Problem ____ Infectious Disease

____ Digestive Problem ____ Lung Disease ____ Headache ____ Other: _____

REVIEW OF SYSTEMS

Please check all symptoms that you currently have or have had:

- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Heart Palpitations
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Heart Attacks/Angina
- ❑ Recurrent Lung
- ❑ Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness Of Breath
- ❑ Pain on Deep Inspiration/Expiration
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies
- ❑ fever
- ❑ Recurrent colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking
- ❑ Pain in to your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/Irritable
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation/Diarrhea
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction