NEW PATIENT INTAKE FORM

Clark CHIROPRACTIC

TODAY'S DATE: _____

PATIENT INFO

FIRST NAME: _____ **LAST NAME:** _____ **BIRTH DATE:** ___/___/___ **AGE:** _____

HOME ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

CELL PHONE: _____ **OTHER PHONE:** _____ **EMAIL:** _____

MALE: ☐ **FEMALE:** ☐ ☐ **SINGLE** ☐ **MARRIED** ☐ **PARTNERED** ☐ **DIVORCED** ☐ **WIDOWED** **# OF CHILDREN:** _____

AGES OF CHILDREN: _____ **OCCUPATION:** _____ **CURRENT EMPLOYER:** _____

EMERGENCY CONTACT NAME: _____ **EMERGENCY PHONE:** _____ **RELATION:** _____

HOW DID YOU HEAR ABOUT CLARK CHIROPRACTIC? _____

CURRENT HEALTH CONDITION

PLEASE INDICATE WHAT CONDITIONS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST. MARK "C" FOR CURRENT CONDITION, MARK "P" FOR PAST CONDITION (3 MONTHS OR LONGER). STAR (*) IF MORE EXPLANATION IS NEEDED.

___ Numbness/Tingling/Pain in Arms, Hands, Fingers - R / L	___ Blurred Vision R / L	___ High Blood Pressure	___ Loss of Taste
___ Numbness/Tingling/Pain in Buttocks, Thighs, Legs, Feet, Toes - R / L	___ Double Vision R / L	___ Tremors	___ Loss of Smell
___ Hip Pain - R / L / BOTH	___ Diarrhea/Constip./Gas	___ Convulsions/Epilepsy	___ Skin Issues
___ Headaches/Migraines	___ Digestive Issues	___ Anemia	___ Cold Hands
___ Neck Stiffness/Pain	___ Irritability/Mood Swings	___ Colon Issues	___ Cold Feet
___ Back Stiffness/Pain	___ Depression	___ Prostate Issues	___ Hot Flashes
___ Fractured Bones	___ Nervousness/Anxiety	___ Heart Condition	___ Cold Sweats
___ Swollen Painful Joints	___ Tension/Stress	___ Kidney Trouble	___ Gall Bladder Issues
___ Foot Issues	___ Dizziness/Vertigo	___ Lung Issues	___ Cancer
___ Arthritis	___ Fatigue	___ Diabetes	___ Stroke
___ Jaw/TMJ Issues	___ Frequent Colds / Flu	___ Ulcers	___ Menstrual Issues/Pain
___ Pain with Cough / Sneeze	___ Upset Stomach	___ Issues Urinating	___ Menopause
___ Buzzing/Ringing in Ears - R / L / BOTH	___ Heartburn/Reflux	___ Bed Wetting	___ Other:
___ Light Sensitivity	___ Shortness of breath	___ Recurring Infection	
___ Sinus Issues / Allergies	___ Chest pain	___ Loss of Balance	

ADDITIONAL EXPLANATION: _____

_____

_____

ARE YOU CURRENTLY PREGNANT OR THINK THAT YOU MAY BE PREGNANT? ☐ YES ☐ NO

REASON FOR TODAY'S VISIT

CHIEF COMPLAINT: _____

_____

IS THIS ISSUE DUE TO: ☐ AUTO ACCIDENT ☐ FALL ☐ TRAUMA ☐ SPORTS INJURY ☐ OTHER/ NOT SURE

PLEASE EXPLAIN: _____

WHEN DID THIS CONDITION BEGIN? _____ **HAS IT OCCURRED BEFORE?** ☐ YES ☐ NO

SINCE THE CONDITION BEGAN, HAS IT: ☐ GOTTEN WORSE ☐ STAYED THE SAME ☐ IMPROVED

WHEN WAS THE LAST EPISODE? _____

HAVE YOU SEEN OTHER DOCTOR(S) FOR THIS CONDITION? ☐ YES ☐ NO

WHAT TREATMENT DID YOU RECEIVE? _____

INTENSITY / SEVERITY

RATE THE INTENSITY OF YOUR SYMPTOMS/CONDITION (SELECT A NUMBER):

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 *SEVERE/INTENSE*

DOES THIS PAIN TRAVEL OR RADIATE? IF SO, WHERE? PLEASE EXPLAIN: _____

_____

QUALITY PLEASE SELECT ALL THAT DESCRIBE THE QUALITY OF THE SYMPTOMS/CONDITION.

☐ Sharp ☐ Dull/Achy ☐ Burning ☐ Throbbing ☐ Crushing ☐ Stabbing

☐ Local ☐ Radiating ☐ Tension ☐ Tingling ☐ Shooting ☐ Numbness

☐ Other (please describe):

TIMING

☐ Worse in A.M. ☐ Worse in P.M. ☐ Worse with activity ☐ Worse sleeping

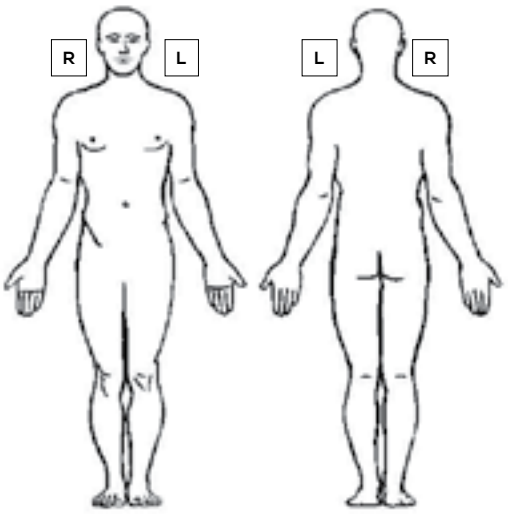
☐ Occasional (0-24%) ☐ Intermittent (25-49%) ☐ Frequent (50 -74%) ☐ Constant (75-100%)

WHAT AGGRAVATES THE CHIEF ISSUE/PAIN? _____

WHAT SOLUTIONS HAVE YOU ATTEMPTED TO SOLVE/RELIEVE YOUR CHIEF ISSUE/PAIN?

_____

USE THE DIAGRAM BELOW TO MARK YOUR AREAS OF DISCOMFORT



IF YOU ARE FILLING OUT THIS FORM ON A COMPUTER, FOLLOW THESE INSTRUCTIONS TO MARK UP THE DIAGRAM*

On the Menu Bar on the right, select COMMENT. A toolbar will show up at the top.

On that toolbar, select the PENCIL icon to activate the Drawing Tool & begin to mark up diagram.

Once complete, click the CLOSE button at the top right to exit out of the Drawing Tool.

DAILY ACTIVITIES: AFFECTS OF CURRENT CONDITION ON YOUR EVERYDAY PERFORMANCE

Bending	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Carrying Groceries	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Changing Positions	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Climbing Stairs	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Driving	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Extended Computer Use	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Household Chores	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Lifting Children	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Reading/Concentrating	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Self Care – Bathing	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Self Care – Dressing	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sexual Activities	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sit to Stand	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sitting	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sleeping	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Standing	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Walking	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Yard Work	☐ No affect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform

IS THERE ANYTHING ELSE THE DOCTOR SHOULD KNOW CONCERNING THIS CONDITION? _____

_____

_____

SECONDARY ISSUE / COMPLAINT: _____

_____

_____

HEALTH HABITS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

DO YOU SMOKE? ☐ YES ☐ NO **HOW OFTEN DO YOU EXERCISE?** ☐ NEVER ☐ FEW TIMES A WEEK ☐ DAILY

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING PAST FAMILY HEALTH HISTORY INFORMATION. PLEASE MARK AN "X" IF YOU OR A FAMILY MEMBER HAS HAD ONE OF THE LISTED CONDITIONS. PLEASE INCLUDE ADDITIONAL INFO AS NEEDED IN THE BOX OR ON THE LINES BELOW.

Condition	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Arthritis						
Anxiety						
Asthma						
Back Issues						
Cancer						
Constipation						
Diabetes						
Difficulty Sleeping						
Disc Issues						
Ear Issues						
Emphysema						
Epilepsy / Seizures						
Fatigue						
Headaches						
Heart Condition / Issues						
High Blood Pressure						
Kidney Issues						
Lung Issues						
Migraines						
Nervousness						
Neck Pain						
Numbness						
Pinched Nerve/Sciatica						
Scoliosis						
Sinus & Allergies						
Stomach Issues						

IS THERE ANYTHING ELSE YOU WOULD LIKE THE DOCTOR TO KNOW? _____

_____

_____