Chiropractic New Patient Intake Form

Wellness Center of the Outer Banks, Inc.

Patient Data **Date:**

First Name: ____________________ **MI:**_______ **Last Name:** ______________________________

Address Line 1: ____

Address Line 2: ____

City: ________________________ **State:** ______ **Zip Code:** _______________________________

Home Phone: ____________________________ **Work Phone:** _____________________________

Cell Phone: ______________________________ **Email:** __________________________________

Date of Birth: ____________________________ **Sex:** ______________

Social Security Number: __________________ **Martial Status:** _________________

Employment Status (circle one): **Employed** **Unemployed** **Student** **Other**

Spouse Data

First Name: ____________________ **MI:**_______ **Last Name:** ______________________________

Home/Cell Phone: ________________________ **Work Phone:** _____________________________

Employer Data

Name: ____

Occupation:____________________ **Job Description:** ____

Address: ____

City: ________________________ **State:** ______ **Zip Code:** _______________________________

Emergency Contact

Contact Name: ____

Phone Number: _____________________ **Relationship to Patient:** ___________________________

How did you hear about our office: ____

Doctor's Signature: ____

Patient Name: ____ **Date:** _________________________

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other: __________________________			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other: __________________________			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish or Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat or Gluten	☐ Other: _________

Social History (Check all that apply to you)

Caffeine Use:	☐ Occasional	☐ Often	☐ Never
Chew Tobacco:	☐ Occasional	☐ Often	☐ Never
Cigarettes:	☐ Occasional	☐ Often	☐ Never
Drink Alcohol:	☐ Occasional	☐ Often	☐ Never
Exercise:	☐ Occasional	☐ Often	☐ Never
Wear Seat Belts:	☐ Occasional	☐ Often	☐ Never

Family History: (Check all that apply to you)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling

Occupational Activities: (Check which option best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Construction
☐ Daycare/Childcare	☐ Executive/Legal	☐ Food Service	☐ Healthcare
☐ Heavy Equipment	☐ Heavy Manual Labor	☐ Home Services	☐ Housekeeper
☐ Light Manual Labor	☐ Manufacturing	☐ Medium Manual Labor	
☐ Other: __________________________			

Doctor's Signature: ____

Patient Name: ____ **Date:** __________________________

Review of Symptoms – Check box if you have had trouble with any of the following, circle NO if none apply.

Cardiovascular			**No**	**Respiratory**			**No**	**Allergic/Immunologic**			**No**
	Past	**Present**			**Past**	**Present**			**Past**	**Present**	
Aortic Aneurysm				Asthma				Allergy Shots			
Chest Pain				Cold/Flu				Cortisone Use			
Heart Attack				Cough				HIV/AIDS			
Heart Disease				Emphysema				Hives			
High Cholesterol				Shortness of Breath				Immune Disorder			
Hypertension				Tuberculosis							
Irregular Heartbeat				Wheezing				**Ear, Nose, and Throat**			**No**
Jaw Pain									**Past**	**Present**	
Pacemaker				**Eyes**			**No**	Bleeding Gums			
Poor Circulation					**Past**	**Present**		Difficulty Swallowing			
Swelling of Legs				Blurred Vision				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			**No**	Glaucoma				Nosebleeds			
	Past	**Present**						Sinus Infection			
Blood in Urine				**Psychiatric**			**No**	Sore Throat			
Burning Urination					**Past**	**Present**					
Frequent Urination				Anxiety				**Gastrointestinal**			**No**
Kidney Disease				Depression					**Past**	**Present**	
Kidney Stones				Stress				Blood Stools			
Lower Side Pain								Bowel Problems			
				Endocrine			**No**	Constipation			
Neurologic			**No**		**Past**	**Present**		Diarrhea			
	Past	**Present**		Diabetes				Gall Bladder Problems			
Brain Aneurysm				Hair Loss				Liver Problems			
Carpel Tunnel				Menopausal				Nausea/Vomiting			
Head Injury				Menstrual				Poor Appetite			
Numbness				Thyroid				Ulcers			
Parkinson's											
Pinched Nerves				**Hematologic**			**No**	**Musculoskeletal**			**No**
Seizures					**Past**	**Present**			**Past**	**Present**	
Severe Headaches				Bleeding				Arthritis			
Stroke				Blood Clots				Broken Bones			
Vertigo				Bruising				Gout			
				Cancer				Joints Replaced			
Constitutional			**No**	Fever/Chills				Joint Stiffness			
	Past	**Present**		Hepatitis				Muscle Weakness			
Difficulty Sleeping				Sweating				Osteoporosis			
Low Energy Level											
Weight Loss/Gain											

Please List all current medications being taken: ____

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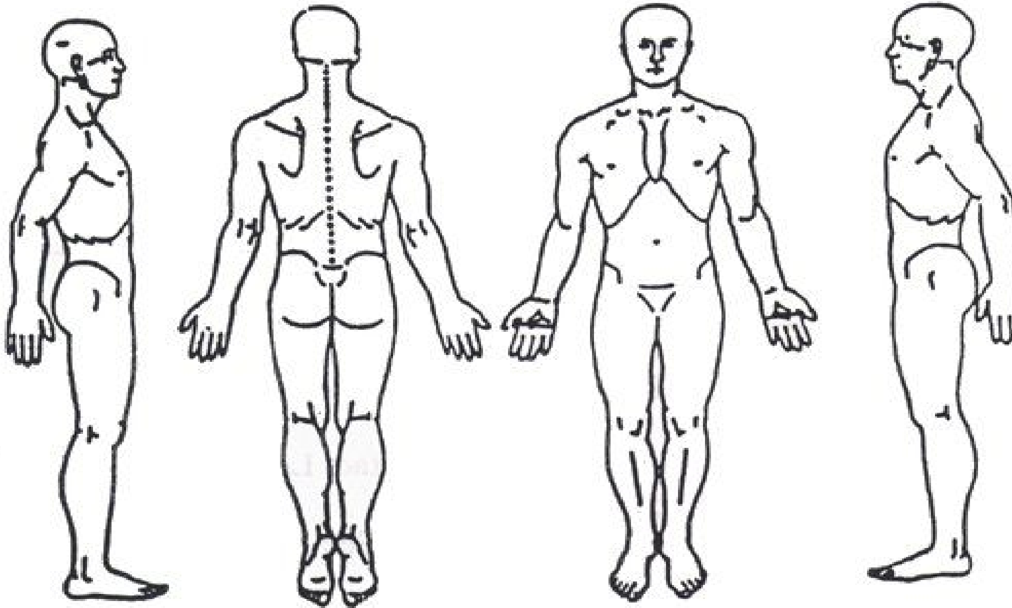
Doctor's Signature: ______________________________________

Patient Name: ______________________________________ **Date:** ________________________

Are you pregnant? ☐ **Yes** ☐ **No** ☐ **N/A**

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N= Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: ________________________

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____

What date your symptoms begin? __________________________

Are your symptoms from: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other: ________________

How did your symptoms begin? ____

____

____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (1-25% of the day)

What describes the nature of your symptoms?

☐ Burning ☐ Dull Ache ☐ Numb ☐ Sharp

☐ Shooting ☐ Stabbing ☐ Tingling ☐ Other: ________________

Doctor's Signature: ____