Performance Chiropractic

NEW PATIENT INTAKE

PATIENT INFORMATION

Today's Date / /

First Name _____ **Last Name**_____ **MI** ____ **Nickname**_____

Address_____ **City** _____ **State**_____ **Zip** _____

Sex ❑M ❑F **DOB** / / **SSN** - -

Marital Status ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated

Primary Phone: ( ) _____ **Email:** _____

Race ❑Am Indian/Alaska Native ❑Asian ❑Black/African Am ❑White(Caucasian) ❑Native Hawaiian/Pacific Islander ❑I Decline to Answer

Ethnicity ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I Decline to Answer **Preferred Language** _____

Referred to us by (❑Friend ❑Relative ❑Physician ❑Internet ❑Yellow Pages) _____

EMPLOYMENT *(check one)* ❑Employed ❑FT Student ❑PT Student ❑Retired ❑Self Employed ❑Other _____

Occupation _____ **Employer** _____

Is today's visit due to an auto accident or work injury? ❑Yes ❑No

If yes, what type? ❑**Auto** ❑**Work** ❑**Other** _____

If yes, has the accident been reported? ❑No ❑Yes

HEALTH HISTORY

Please list **Medications** and **Reason** for taking ❑**None**

1) _____

2) _____

3) _____

4) _____

Please list **Illnesses** and **Medical Conditions** ❑**None**

_____

_____

Please list known **Allergies** ❑**None**

_____

Please list previous **Surgeries** ❑**None**

_____

Please list previous **Injuries** ❑**None**

_____

Please list previous **Hospitalizations** ❑**None**

_____

SOCIAL HISTORY

Tobacco Exposure:

Smoke/Use Tobacco, including **e-Cigarettes**: ❑Never ❑Quit ❑Yes

Exposed to **Second-Hand Smoke** or **Vapor** ❑No ❑Yes

Exercise:

Days per week _____? ❑Light ❑Moderate ❑Intense

My **Work/Daily** activities include:

❑Standing ❑Sitting ❑Light Labor ❑Heavy Labor ❑Other

My **Habits** include:

❑Substance Abuse ❑High Negative Stress ❑Quality Sleep

❑Alcohol ❑Soft Drinks ❑Water ❑Coffee/Tea ❑Quality Diet

Dietary Supplements: ❑Probiotic ❑Fish Oil/Omega ❑Vit D3 ❑Sports ❑None ❑Other _____

FEMALES ONLY

Are you currently pregnant? ❑ Yes ❑ No *If yes, how many weeks?* _____ *Do you have a birth plan?* ❑ Yes ❑ No

Pregnancy History Number pregnancies_____ Number of live births_____ Type of Delivery_____

FAMILY HISTORY Have your ***Grandparents*, *Parents*, *Siblings*, *Spouse*, or *Children*** had any of the following? (*check all that apply*)

❑**None** ❑Arthritis ❑Cancer/Tumor ❑Heart Disease ❑Mental Illness ❑Dementia ❑Stroke ❑Obesity ❑Diabetes ❑Parkinson's

❑High Blood Pressure ❑Thyroid Disorder ❑High Cholesterol ❑Autoimmune Disorder ❑Other_____

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(701) 732-2888

File#_____

Performance Chiropractic

NEW PATIENT INTAKE

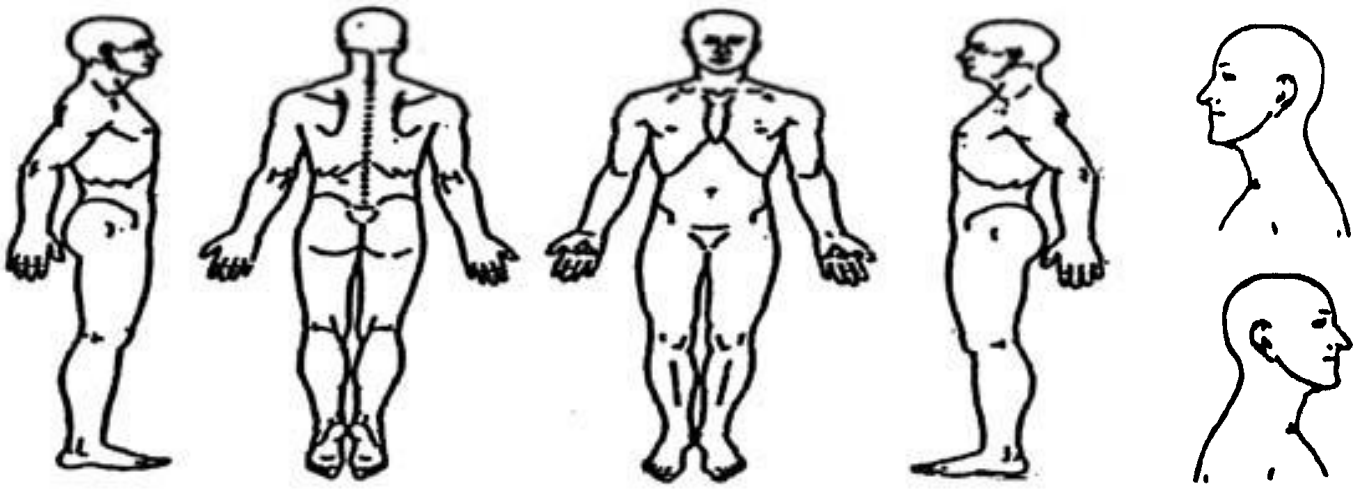
Family Physician _____ **City** _____ **Date of Last Visit** / /

** May we share information in our patient records with your above listed physician for integrated care?* ❑ Yes ❑ No

Have you had chiropractic care before? ❑No ❑Yes *If yes, for what problem?* _____ **Date of Last Visit** / /

HEALTH PROBLEM

PLEASE MARK (x) AREAS OF YOUR SYMPTOMS ON THE DIAGRAMS BELOW



What is your main problem? _____

When did this problem begin? _____

How did this problem begin? ❑Suddenly ❑Gradually ❑Post-Injury

How is your problem changing? ❑Getting Better ❑Getting Worse ❑Not Changing ❑Not Sure

Have you had this problem before? ❑Yes ❑No

- *If yes, when was the last episode?* _____

Have you previously sought care elsewhere for this problem? ❑Yes ❑No

- *If yes, were any tests ordered? (e.g. x-ray, MRI)* _____

How frequently do you notice your symptoms during the day? ❑**NEVER** ❑**SOMETIMES** ❑**OFTEN** ❑**ALWAYS** _____**% of day**

How do your symptoms feel?

❑Sharp ❑Dull/Ache ❑Numb ❑Burning ❑Shooting ❑Tingling ❑Tight ❑Radiating Pain ❑Stabbing ❑Throbbing ❑Pulling

❑Other _____

Do your symptoms travel from the main problem to another part of your body sometimes? *(e.g. arms or legs)* ❑Yes ❑No

Are your symptoms consistently worse at a certain time of day? ❑Morning ❑Afternoon ❑Evening ❑Night ❑Unaffected by time of day

Please rate your symptoms during the last 24 HOURS *(0=No Pain and 10=Pain as bad as it could be)*

At BEST	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
At WORST	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

What makes your problem WORSE? *(e.g. working, sitting, exercise, etc.)* _____

What makes your problem BETTER? *(e.g. ice, heat, massage, etc.)* _____

X Patient Signature _____

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REVIEW OF SYSTEMS **Instructions:** Please fill out all of the sections. If none of the conditions apply to you, please select ***None***.

Ears/Nose/Throat
- ☐ **None**
- ☐ Bleeding Gums
- ☐ Dizziness
- ☐ Ear Infection
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Tinnitus (*ringing in ears*)

Cardiovascular
- ☐ **None**
- ☐ Poor Circulation
- ☐ High Blood Pressure
- ☐ Aortic Aneurism
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Chest Pain with exertion
- ☐ High Cholesterol
- ☐ Pace Maker
- ☐ Jaw Pain
- ☐ Irregular Heartbeat
- ☐ Swelling of Legs
- ☐ Varicose Veins

Neurological
- ☐ **None**
- ☐ Muscle Twitching
- ☐ Seizures
- ☐ Head Injury
- ☐ Brain Aneurysm
- ☐ Numbness/Tingling
- ☐ Severe Headaches
- ☐ Pinched Nerves
- ☐ Carpal Tunnel
- ☐ Spinning/Loss of Balance
- ☐ Facial Weakness
- ☐ Limb Weakness
- ☐ Slurred Speech
- ☐ Tremors
- ☐ Loss of Consciousness

Musculoskeletal
- ☐ **None**
- ☐ TMJ Disorder
- ☐ Gout
- ☐ Arthritis
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis
- ☐ Broken Bones
- ☐ Joint Replacement
- ☐ Difficulty Walking
- ☐ Upper Extremity Pain
- ☐ Lower Extremity Pain
- ☐ Back/Neck Pain

Eyes/Vision
- ☐ **None**
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Glaucoma
- ☐ Itching (around the eyes)
- ☐ Wears Glasses/Contacts

Respiratory
- ☐ **None**
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Cold/Flu
- ☐ Cough/Wheezing
- ☐ Sputum Production

Skin/Breast
- ☐ **None**
- ☐ Skin Ulcers
- ☐ Skin Disease
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Sensation Changes
- ☐ Lump(s)
- ☐ Hair Loss/Growth

Hematologic/Lymphatic
- ☐ **None**
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Hepatitis

Psychiatric
- ☐ **None**
- ☐ Anxiety
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Excessive Stress
- ☐ Memory Loss
- ☐ Drug/Alcohol Dependence

Endocrine
- ☐ **None**
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Thyroid Disease
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Gastrointestinal
- ☐ **None**
- ☐ Abdominal Pain
- ☐ Digestive Problems
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bowel Problems
- ☐ Liver Problems
- ☐ Gallbladder Problems
- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Poor Appetite

Genitourinary
- ☐ **None**
- ☐ Painful Urination
- ☐ Incontinence
- ☐ Discolored Urine
- ☐ Bladder Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lower Side Pain
- ☐ Sexual Dysfunction
- ☐ STD

Constitutional
- ☐ **None**
- ☐ Energy Level Problems
- ☐ Dizziness or Diarrhea
- ☐ Weight Loss/Gain > 10 lbs
- ☐ Fevers/Chills/Night Sweats
- ☐ Loss of appetite/Nausea

Females
- ☐ **None**
- ☐ Birth Control
- ☐ Breast Lumps/Pain
- ☐ Cramps
- ☐ Menopausal
- ☐ Hormone Therapy
- ☐ Irregular Menstruation

Males
- ☐ **None**
- ☐ Erectile Dysfunction
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems

Allergic/Immunologic
- ☐ **None**
- ☐ Hives
- ☐ Immune Disorder
- ☐ HIV/AIDS
- ☐ Allergy Shots
- ☐ Cortisone Use

For Office Use Only

Height: _____ **Weight: _____** **Heart Rate: _____** **Blood Pressure: _____ /_____**

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