Riverside Chiropractic Health Center

New Patient Intake Form

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION:**

Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex \_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Zip Code: \_\_\_­\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Number: \_\_\_\_\_\_\_\_\_\_Mobile Number: \_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer + Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_Weight \_\_\_\_\_\_\_Hobbies \_\_\_\_\_\_\_\_\_How did you hear about our office:\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_

**Patient Condition:**

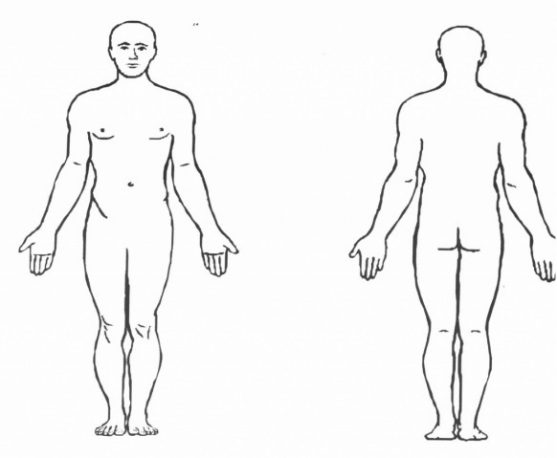
Reason(s) or visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please indicate type and severity of pain/discomfort with the below key on the diagram:

|  |
| --- |
| Type of Pain: A=Achy S=Sharp  N=Numb C=Cramps T=Tight  Pain: Scale 0-10  1=Mild 10=Severe |

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When & how did your symptoms appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you have this pain/sensation?  0/25% of the day

26/50% of the day  51/75% of the day  76/100% of the day

Does it interfere with your Work Sleep Daily Routine Recreation  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities or movements thast are painful to perform  Sitting  Standing  Walking Bending Lying Down  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerend about your posture? Yes  No

**HEALTH HISTORY:**

What treatment have you already received for your condition?  Chiropractic  Physical Therapy

Massage  Stretching  Acupuncture  Surgery  None  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications including Over The Counter (if so what kind and how much):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epidural or steroid Injection (if so how many and when):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all health care professionals seen for this/these issue(s) including type of doctor: (ex. Primary doctor, Orthopedic, podiatrist, emergency room, chiropractors, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list estimated dates of the following: Physical: \_\_\_\_\_\_\_\_\_ Spinal Exam \_\_\_\_\_\_\_\_

Spinal X-Ray: \_\_\_\_\_\_\_MRI:­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CT Scan:\_\_\_\_\_\_\_\_\_\_\_ Bone Scan:\_\_\_\_\_\_\_\_\_\_\_

Blood Test: \_\_\_\_\_\_\_\_

List all strains/ sprains/ broken bones, how they happened and estimated dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all hopspitalizations and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes No Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list including doseages and how many times a day:

Medications (What & Why) Vitamins/Herbs/Minerals

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check box yes or no to indicate if you have any of the following:**

AIDS/HIV Yes  No

Alcoholism Yes No

Allergies Yes No

Anemia Yes No

Anorexia Yes No

Anxiety Yes  No

Appendicitis Yes  No

Asthma Yes  N

Breast Lump Yes No

Bronchitis Yes No

Cancer Yes No

Cataracts Yes  No

Cavities(Dental) Yes  No

Chicken Pox Yes  No

Chemical Dependency Yes No

Diabetes Yes No

Diarrhea/ Constipation Yes  No

Difficulty SleepingYes No

Epstein Barr Yes No

Epilepsy Yes No

Emphysema Yes No

Fibromyalgia Yes No

GastroDiscomfortYes No

Glaucoma Yes No

Gout Yes No

Goiter Yes No

Heart issues Yes No

Hepatitis Yes No

Hepes Yes No

Herniated Disk YesNo

High Blood SugarYes No

Headaches Yes  No

Kidney ProblemsYes  No

Liver Disease Yes No

Measles Yes No

Memory Loss Yes  No

Menstrual CrampsYesNo

Migraines Yes No

Mononucleosis Yes  No

Multiple Sclerosis Yes No

Osteopenia Yes No

Osteoporsosis Yes No

Parkinsons Yes No

Pacemaker Yes No

Pinched Nerve Yes No

Prostate ProblemsYesNo

Prosthesis Yes No

Psychiatric Care Yes No

Sinus Problems Yes No

Skin Rashes Yes No

Stroke Yes No

STD/STI Yes No

Suicide Attempt Yes  No

Thyroid ProblemsYes No☐

Tumors/ Growths YesNo

Ulcers Yes No

Vaginal InfectionsYes No

Vison Problems Yes No

Exercise: Work Activity: Habits:

None  Sitting  Smoking Packs/ Day \_\_\_\_\_\_\_\_\_\_\_

Moderate  Standing  Alcohol Drinks Week\_\_\_\_\_\_\_\_\_\_\_

Daily  Light Labor  Caffeine Drinks Cups/Day \_\_\_\_\_\_\_\_\_\_\_

Heavy  Heavy Labor  High stress Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you be interested in taking a Whole Body System Evaluation?

This includes 1) An evaluation for nutritional deficiences 2) Identifying any systems organs and/or glands that need support 3)Optimal blood Work Analysis from most recent bloodwork. Yes No Maybe

Is there anything els you would like Dr.Holstein to know about you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_