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 Yes[ ] No[ ]

High Blood SugarYes[ ]  No[ ]

Headaches Yes [ ]  No[ ]

Kidney ProblemsYes [ ]  No[ ]

Liver Disease Yes[ ]  No[ ]

Measles Yes[ ]  No[ ]

Memory Loss Yes [ ]  No[ ]

Menstrual CrampsYes[ ] No[ ]

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 ProblemsYes[ ] No[ ]

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 Yes[ ] No[ ]

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?

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