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:

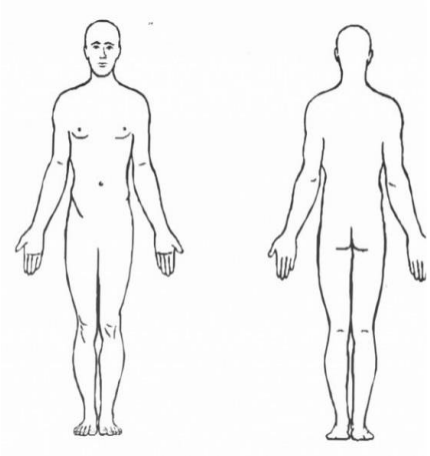
Reason(s) or visit:

_____

_____

_____

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

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 that 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
_____	_____
_____	_____
_____	_____
_____	_____

Work Activity:	Habits:	
☐ Sitting	☐ Smoking	Packs/ Day _____
☐ Standing	☐ Alcohol	Drinks Week_____
☐ Light Labor	☐ Caffeine	Drinks Cups/Day _____
☐ Heavy Labor	☐ High stress	Reason_____

Do you exercise on a regular basis? ☐ Yes ☐ No

If answered yes what kind of excerise do you do?

_____
_____
_____

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

_____
_____
_____

What are your goals for your care here?

_____
_____
_____

Patient Signature_____ Date_____

Doctor Signature_____ Date_____