Abundant Life CHIROPRACTIC

PATIENT INTAKE FORM

PLEASE TELL US ABOUT YOU

Today's Date ____/___/ ____

Full Legal Name _____

Male __ Female __ Single___ Married___ Widow___ Divorced___

How you prefer to be addressed _____ Birthdate _____/_____/_____ Age_____

Social Security # _____-_____- _____ E-mail address_____

Street Address _____ Phone ____-____-_____

City _____ State _____ Zip Code _____

Employer's Name _____ What do you do there? _____

Employer's Address _____ Years with present employer _____

Work Phone # _____-_____- _____ Ext. # _____ Okay to call you at work? Yes No

Referred to our office by _____

In Case of Emergency Contact _____ Phone # ____-_____-_____ Relationship _____

INSURANCE INFORMATION

Is your current condition the result of an accident/injury? Yes __ No ___ If yes: Auto __ Work __ Slip/Fall __

Primary Insurance Company

Ins. Co. Name _____ Group # (Plan, Local or Policy #) _____

Address _____ Insured's Name _____

_____ Relation _____ Birthdate _____

Ins. Co. Phone # _____ Insured's Social Security # _____

Insured' s Employer _____ Address _____

Secondary Insurance Company

Ins. Co. Name _____ Group # (Plan, Local or Policy #) _____

Address _____ Insured's Name _____

_____ Relation _____ Birthdate _____

Ins. Co. Phone # _____ Insured's Social Security # _____

Insured's Employer _____ Address _____

Patient Acknowledgement

By my signature, I understand and acknowledge that ***Abundant Life Chiropractic***, its Physicians and agents, will treat my condition as they deem necessary through the use of Chiropractic Manipulative Therapy and adjunctive therapies. I also understand that all original documents and original x-rays created as a result of the performance of examinations will remain the property of ***Abundant Life Chiropractic***, it's Physicians and agents, will not be held responsible for any undisclosed pre-existing conditions. As the parent, guardian or parentally authorized agent, I hereby authorize ***Abundant Life Chiropractic***, it's Physicians and agents, to administer care to this minor.

Signature of Patient (Responsible Person) _____ Date: ____/____/___

Please check the appropriate box(es) for any of the following symptoms of ill health which you may now have or have had previously. In order to provide necessary chiropractic care we need to know all the facts related to your health. This is a Confidential Health Report.

- ☐ Headaches
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Pins + Needles in Arms
- ☐ Pins + Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Pain in the Arms
- ☐ Pain in the Legs
- ☐ Pain between Shoulders
- ☐ Hands Cold
- ☐ Feet Cold
- ☐ Neck Stiff
- ☐ Back Stiff
- ☐ Convulsions
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Eyes Sensitive to Light
- ☐ Loss of Memory
- ☐ Ringing in the Ears
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Poor Digestion
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Chronic Cough

Have you ever?

Yes	No	
☐	☐	Been Knocked Unconscious?
☐	☐	Used Crutches or other Support?
☐	☐	Been Treated for Spine Problems?
☐	☐	Been Treated for any Nerve Disorder?
☐	☐	Had a Fractured/Broken Bone?
☐	☐	Had Surgery?
☐	☐	Been Hospitalized for Other than Surgery?

Date of Last : (approximate)

- _____ Physical Examination
- _____ Blood Test
- _____ Urine Test
- _____ Chest X-ray
- _____ Spine X-ray
- _____ Dental X-ray
- _____ Other

Habits:

Have you in the past or do you currently use:

- ☐ Alcohol If yes how often? _____
- ☐ Coffee How many cups per day?_____
- ☐ Tobacco How many pack per day? _____

Is there a Family History of?

- ☐ Heart Disease ☐ Arthritis
- ☐ Cancer ☐ Diabetes
- ☐ Stroke ☐ _____

Your Current Problem

What are you current symptoms? 1. _____ 2. _____

3. _____ 4. _____

What level of intensity would you rate your pain? (10=severe) ***1 2 3 4 5 6 7 8 9 10***

What is the frequency of your symptoms? ***Occasional / Episodic / Intermittent / Frequent / Constant***

Do your symptoms affect your personal life? (hobbies, sports, etc) _____

_____

Do your symptoms affect your job / occupation?(missed days, inability to stand, sit, lift, drive) _____

_____

How long have you suffered from these symptoms? _____

Have you suffered from these symptoms before? ☐ Yes ☐ No

What makes your symptoms worse? _____

What makes your symptoms better? _____

What home remedies have you tried? _____

Have you been to any other type of doctor for this problem? _____

Have you been to a Chiropractor before? ☐ Yes ☐ No If Yes, Who?_____

After completing this questionnaire your signature will verify that all information you have given is to accurate to the best of your knowledge.

Signed: _____ Date: _____

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