Mills Chiropractic & Wellness Center, P.A.

13795 S. Mur-Len Rd. Ste. #203
Olathe, KS 66062
(913) 764-5900
www.millswellness.com

New Patient Intake Form

Patient Data

Name: _____ Date of Birth: _____ Sex: ____

Address:_____ Home #: _____

City: _____ State: _____ Zip: _____ Cell # _____

E-Mail: _____ Preferred Contact Method? _____

- ☐ I want to receive appoint reminders via text message (standard carrier rates/fees may apply).
- ☐ I want to receive appointment reminders via email.
- ☐ I want to receive information and announcements via email.

Relationship Status: _____ Currently pregnant? Y / N
# of Children: _____ Ages: _____

Emergency Contact: _____ Phone #: _____

Whom may thank for referring you? _____

Primary Care Physician: _____

Address/Facility: _____

"I authorize Mills Chiropractic & Wellness Center to share their findings, treatments, outcomes, and other relevant information from my care here with the physician listed above." If so, please sign below.

Signature: _____ Date: _____

Guarantors Information (person carrying insurance)

Name: _____ Date of Birth: _____ Sex: M / F

Address:_____ Relationship: _____

City: _____ State: _____ Zip: _____ Phone #:_____

"I authorize Mills Chiropractic & Wellness Center to bill my insurance company for the charges incurred. I agree to abide by the rules and regulations set forth by my policy." If so, please sign below.

Signature: _____ Date: _____

For Office Use

__Ins Card __DL __ Rapid __CU __PP __Welcome __Photo __Dr. call __Scanned __Uploaded

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What brings you to our office? ☐ Automobile Accident ☐ Non- Accident/Trauma ☐ Other Injury ☐ Wellness Care

Please answer the following sections as they apply to you based on your answer above.

Automobile Accident -OR- Other Injury Only (please circle all that apply)

When did it occur? _____

Immediately after the accident/injury, did you feel dazed? Yes No
Did you lose consciousness? Yes No
Was your head injured? Yes No

Immediately after the accident, did you experience: Headaches Neck Pain Low back pain

Did you see another doctor before coming here? Yes No If yes, name of doctor: _____

Did you go to a hospital after the accident/injury? Yes No If yes, which hospital? _____

How did you get to the hospital? Ambulance Drove Self Police Somebody else

Were any of the following test performed at the hospital? X-rays MRI CT Labs

Did the injury occur on the job? Yes No
Was it reported? Yes No

Automobile Accident Only (please circle all that apply)

What was your position in the vehicle? Driver Front Passenger Rear Passenger

What was the damage to the vehicle? Mild Moderate Extensive Totals

What was the visibility on the road? Poor Fair

And the weather was: Clear Raining Windy Foggy Snowing

How did the accident happen? I hit another vehicle Another vehicle hit me I hit an object

The point of impact on your vehicle was…? (please describe):

_____

Did you see the accident coming? Yes No Were you braced for the impact? Yes No

Where you wearing a seatbelt? Yes No Does your vehicle have an airbag? Yes No

Did the airbag deploy? Yes No Does your vehicle have headrest? Yes No

What was the position of the headrest?
Even with top of head Even with bottom of head Middle of neck

Did you strike anything inside the vehicle? Yes No If yes, what? _____

Which way was your head turned during the accident? Straight Turned Right Turned Left

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ALL cases (automobile, non-accident/trauma, injury and wellness care) (please circle)

Do you feel your condition / health is: Improving Staying the same Getting worse

Have you lost time from work? Yes No
Can you perform physical work activities? Yes No
If no, because of: Pain Weakness Stress

Activates of Daily Living Please circle all activates with which you are currently experiencing problems.

Seeing	Tasting	Smelling	Eating	Hearing	Insomnia
Dressing	Reading	Typing	Writing	Grasping	Using the toilet
Standing	Leaning	Walking	Stooping	Squatting	Loss of sexual drive
Bending	Twisting	Carrying	Lifting	Pushing	Restful sleeping
Sitting	Driving	Sports	Exercising	Reclining	Loss of concentration
Irritable	Riding in car	Air travel	Climbing	Pulling	Changes in personality
Grooming	Pinching	Kneeling	Reaching	Nervous	Tactile feeling

Can you sleep without problems? Yes No
Do you awaken because of pain? Yes No
Did you have sleep problems before? Yes No

Social History: (please circle appropriate responses)

Do you currently use alcohol? No Yes, type and amount per week: _____

Do you use other recreational drugs? No Yes, type and amount per week: _____

Do you exercise? No Yes, type and amount per week: _____

What is your current smoking status?

- ☐ Current every day smoker – Amount per week: _____
- ☐ Current some day smoker – Amount per week: _____
- ☐ Former smoker – Date stopped: _____
- ☐ Never smoker

Have you been abused? Yes No Are you currently being abused? Yes No

Allergies:

- ☐ Chemical _____
- ☐ Environmental_____
- ☐ Seasonal_____
- ☐ Other_____
- ☐ Food_____

Do you have any medication allergies?

- ☐ No, I have no known medication allergies.
- ☐ Yes: _____

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Medications/Supplements:

Are you currently taking any <u>prescription</u> medications?

☐ No, not currently prescribed any medications.

☐ Yes, Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Use the space below to continue listing if needed.

Are you currently taking any <u>non-prescription</u> medications, vitamins, or supplements?

☐ No, not currently taking anything else.

☐ Yes, Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Use the space below to continue listing if needed.

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Surgical History (please circle all surgeries you have had in the past)

Abdominal exploration	Abdominoplasty	Abortion	ACL reconstruction
Adenoid removal	Angioplasty	Appendectomy	Bone fracture repair
Breast lump	Bunion removal	Carotid artery surgery	Cataract surgery
Cervical spine surgery	Cholecystectomy	Cosmetic breast	C-Section
Facelift	Gallbladder Removal	Gastric Bypass	Heart Bypass
Heart Surgery	Hemorrhoid	Hernia Repair	Hip Joint Replacement
Hysterectomy	Kidney Transplant	Knee Arthroscopy	Knee Replacement
LASIK eye	Liposuction	Lumbar Spine	Mastectomy
Prostate Removal	Rotator Cuff	TMJ	Vasectomy

Tonsillectomy Other: _____

Family History: (please circle all conditions that run in your family)

Abdominal pain	Weight gain/loss	Angina	Anorexia	Anxiety
Arthritis	Aortic aneurysm	Asthma	Bladder infection	Blood disorder
Breast Lumps	Breast soreness	Bronchitis	Cancer	Cardiovascular
Chest Pain	Chronic cough	Chronic sinusitis	Colitis	Constipation
Convulsions	COPD	Depression	Dermatitis	Diabetes
Difficulty in swallowing	Dizziness	Emphysema	Endometriosis	Epilepsy
Excessive thirst	Fainting	Frequent urination	General fatigue	Gout
Hand pain	Headache	Heart attack	Heart disease	
Heartburn/Indigestion	Hepatitis	High Blood pressure	High Cholesterol	High PSA
High triglycerides	Hypertension	Irregular menstrual flow	Irritable colon	Jaw pain
Kidney disorders	Kidney stones	Liver/Gallbladder	Loss of appetite	Bladder control
Low back pain	Lung disease	Mental disease	Mid back pain	Neck pain
Muscular incoordination	Osteoarthritis	Foot/ankle pain	Knee pain	Leg/Hip Pain
Arm/elbow pain	Painful urination	Pneumonia	Profuse menstrual flow	PMS
Prostate problems	Rapid heartbeat	Renal disease	Rheumatoid arthritis	Scoliosis
Shoulder pain	Stroke	Swelling/stiff joints	Thyroid disease	Tinnitus
Tuberculosis	Tumor	Ulcer	Visual disturbances	Wrist pain

Other: _____

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Past Medical History (Please circle all conditions that you have had or are currently having)

Abdominal pain	Weight gain/loss	Angina	Anorexia	Anxiety
Arthritis	Aortic aneurysm	Asthma	Bladder infection	Blood disorder
Breast Lumps	Breast soreness	Bronchitis	Cancer	Cardiovascular
Chest Pain	Chronic cough	Chronic sinusitis	Colitis	Constipation
Convulsions	COPD	Depression	Dermatitis	Diabetes
Difficulty in swallowing	Dizziness	Emphysema	Endometriosis	Epilepsy
Excessive thirst	Fainting	Frequent urination	General fatigue	Gout
Hand pain	Headache	Heart attack	Heart disease	Wrist pain
Heartburn/Indigestion	Hepatitis	High Blood pressure	High Cholesterol	High PSA
High triglycerides	Hypertension	Irregular menstrual flow	Irritable colon	Jaw pain
Kidney disorders	Kidney stones	Liver/Gallbladder	Loss of appetite	Bladder control
Low back pain	Lung disease	Mental disease	Mid back pain	Neck pain
Muscular incoordination	Osteoarthritis	Foot/ankle pain	Knee pain	Leg/Hip Pain
Arm/elbow pain	Painful urination	Pneumonia	Profuse menstrual flow	PMS
Prostate problems	Rapid heartbeat	Renal disease	Rheumatoid arthritis	Scoliosis
Shoulder pain	Stroke	Swelling/stiff joints	Thyroid disease	Tinnitus
Tuberculosis	Tumor	Ulcer	Visual disturbances	

Other: _____

Chief Complaint

Please list your complaints/concerns in order of importance to you:

1.) _____ Your biggest concern with is problem is: _____

2.) _____ Your biggest concern with is problem is: _____

3.) _____ Your biggest concern with is problem is: _____

4.) _____ Your biggest concern with is problem is: _____

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Complaint # 1 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

Complaint # 2 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

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Complaint # 3 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

Complaint # 4 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			