Bangor Family Chiropractic
A Maine Vitality Center

New Member Intake Information

PERSONAL INFORMATION

Name:_____ Spouse/Partner:_____

Address: _____City: _____State: _____Zip:_____

E-Mail: _____

Home Phone: _____Cell Phone: _____

Date of Birth: _____Age: _____ Gender: M F Marital Status: M S W D

Number of children and ages: _____

Social Security Number: _____

Employer: _____Position: _____

Work Phone: _____Ext: _____

In case of emergency, Notify: _____Phone: _____

Primary Care Physician: _____Phone: _____

Who should we thank for telling you about our office? _____

INSURANCE INFORMATION

Insurance Company:_____ Phone: _____

Name of Primary Card Holder:_____ Date of Birth:_____

Card Holder's Place of Employment: _____

CURRENT HEALTH CONCERN

Reason for Today's Visit: _____

_____

_____

Circle Level of Discomfort:

1 2 3 4 5 6 7 8 9 10

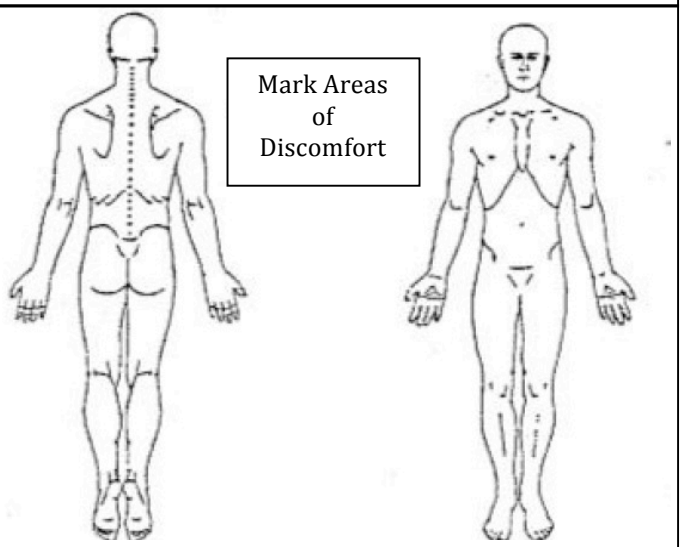
Mild ***Severe***

Date Symptoms First Appeared:_____

Is this Condition:

___Work Related ___Fall/Injury ___Auto Accident

___Other _____



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CURRENT HEALTH CONCERN

In your own words, describe what is currently going on: _____

_____

_____

_____

_____

_____

What makes it Better: _____

What makes it Worse: _____

What other treatments have you tried: _____

Is your pain: ___ Constant ___ Intermittent ___ Only with Movement

Have you had this problem before? ___Yes ___No If Yes, When? _____

FAMILY HISTORY

Family Member	Significant Past & Present Health Conditions
_____	_____
_____	_____
_____	_____

PAST HEALTH EVENTS

Previous Surgeries:

___ Eyes/Ears/Nose/Throat ___Head/Neck ___Back/Spine ___Chest/Heart/Lungs ___ Abdominal

___Other: _____

Previous Fractures or Broken Bones?	Yes	No	Explain: _____
Previous Falls or Accidents?	Yes	No	Explain: _____
Previous Hospitalizations?	Yes	No	Explain: _____
Previous Auto Accidents?	Yes	No	Explain: _____
Previous Chiropractic Care?	Yes	No	Explain: _____
Do you Workout or Exercise?	Yes	No	Explain: _____
Do you take any Medications?	Yes	No	Explain: _____
Do you take any Vitamins/Herbs?	Yes	No	Explain: _____
Have you ever had X-Rays taken?	Yes	No	Is Yes, Where: _____

Date of last Physical Exam: _____ Are you Pregnant? Yes No

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CHECK ALL THAT APPLY

Health Issues:

___ Polio	___ Arthritis	___ Diabetes	___ Sleeplessness
___ Cancer	___ AIDS or ARC	___ Heart	___ Chronic Fatigue
___ Frequent Illness	___ Allergies	___ High Stress	___ Poor Diet
___ Genetic Disorders	___ Epilepsy	___ Over Weight	___ Under Weight

___ Other: _____

Habits:	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	___	___	___	___
Tobacco	___	___	___	___
Drugs	___	___	___	___
Pain Reliever's	___	___	___	___
Caffeine	___	___	___	___
Sleep	___	___	___	___
Artificial Sweeteners	___	___	___	___
Exercise	___	___	___	___
Water	___	___	___	___

CHECK ANY PROBLEM YOU HAVE EVER SUFFERED FROM

__ Low Back Pain	__ Middle Back Pain	__ Neck Pain	__ Shoulder/Arm Pain
__ Joint Pain/Stiffness	__ Hip/Leg Pain	__ Chest Pain	__ Lungs/Breathing
__ Blood Pressure	__ Heart Rate	__ Sinus Pain	__ Sinus Infection
__ Eyes/Vision	__ Throat/Voice	__ Hearing	__ Ear Infections
__ Dental/TMJ	__ Headaches	__ Nervousness	__ Numbness/Tingling
__ Muscle weakness	__ Dizziness	__ Forgetfulness	__ Depression
__ Fainting	__ Cold Hands/Feet	__ Seizures	__ Stress Reactions
__ Shaking/Tremors	__ Poor Appetite	__ Nausea	__ Excessive Thirst
__ Diarrhea	__ Constipation	__ Hemorrhoids	__ Weight Loss/Gain
__ Heartburn	__ Change in Stool	__ Genital Issues	__ Pain w/Urination
__ Frequent Urination	__ Infrequent Urination	__ Weak Stream	__ Bladder Control
__ Menstrual	__ Fertility Issues	__ Lumps *(Breast/Genital)*	

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

I certify that I have completed this form to the best of my ability, and the statements I have provided are true.
I also agree that I am aware of Slocum Chiropractic HIPPA privacy policy.

Patient Name *(Please Print):* _____

Patient/Guardian Signature: _____ Date: _____

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