



# Oak Springs Chiropractic: A Creating Wellness Center

## New Practice Member Intake Form

Name: \_\_\_\_\_ Called Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed Occupation: \_\_\_\_\_  
 Email: \_\_\_\_\_

In case of an emergency, please contact: Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Your Health Profile

**Primary Complaint** (*List one only*): \_\_\_\_\_

**Onset:** \_\_\_\_\_

**Presentation:** \_\_\_\_\_

**Quality - pain type:**

- mild  moderate  severe  aching  burning  deep  dull  nagging  numbing  piercing
- pins and needles  raw  sharp  shooting  stabbing  stinging  superficial  throbbing  other

**Location:**  left  right  both

**Severity 0-10:**

with activity \_\_\_\_\_ without activity \_\_\_\_\_ with work activity \_\_\_\_\_ without work activity \_\_\_\_\_

**Frequency of Pain:** % of awake time \_\_\_\_\_ sporadic \_\_\_\_\_ intermittent \_\_\_\_\_ constant \_\_\_\_\_  
 occasional \_\_\_\_\_ persistent \_\_\_\_\_ constant but varies \_\_\_\_\_ none \_\_\_\_\_ other \_\_\_\_\_

**Aggravating factors:**

- bearing weight  bending  coughing  driving  exercise  household chores
- lying on back  lifting  looking down  looking up  movement  reaching  resting  rotating head
- rotation  scooping  sitting  sleeping  sneezing  stair stepping  standing  stooping  straining
- twisting  typing  walking  working

**Relieving factors:**

- adjustment provided  topical analgesic applied  lying on back with knees up
- exercises/stretched  heat  ibuprofen  ice  lying down  leaning against a support  medication
- movement occurs  no movement occurs  resting  sitting  standing  watching TV

**Pain radiates to:** neck middle back upper extremities lower back lower extremities

**Pain is worse in the:** morning afternoon evening

**Activities of Daily Living - Difficulties:** Child Care Computer Dancing Eating Sleeping  
Walking Yard Work Shopping Sexual Intercourse Hobbies Sporting Activities Household  
Duties Play with Child Driving Social Activities Religious Events Gardening Working  
Exercising Exercise Class Gym Class Jogging Mowing Lawn Paperwork Racquet Ball  
Reading Hockey Sitting Standing Swimming Up/Down Stairs Vacuuming Washing the  
Car Washing Windows Weeding Weight Lifting Other\_\_\_\_\_

**Secondary Complaint (List one only):** \_\_\_\_\_

**Onset:** \_\_\_\_\_

**Presentation:** \_\_\_\_\_

**Quality - pain type:**

mild moderate severe aching burning deep dull nagging numbing piercing  
pins and needles raw sharp shooting stabbing stinging superficial throbbing other

**Location:** left right both

**Severity 0-10:**

with activity\_\_\_\_\_ without activity\_\_\_\_\_ with work activity\_\_\_\_\_ without work activity\_\_\_\_\_

**Frequency of Pain:** % of awake time\_\_\_\_\_ sporadic\_\_\_\_\_ intermittent\_\_\_\_\_ constant\_\_\_\_\_  
occasional\_\_\_\_\_ persistent\_\_\_\_\_ constant but varies\_\_\_\_\_ none\_\_\_\_\_ other\_\_\_\_\_

**Aggravating factors:** bearing weight bending coughing driving exercise household chores  
lying on back lifting looking down looking up movement reaching resting rotating head  
rotation scooping sitting sleeping sneezing stair stepping standing stooping straining  
twisting typing walking working

**Relieving factors:** adjustment provided topical analgesic applied lying on back with knees up  
exercises/stretched heat ibuprofen ice lying down leaning against a support medication  
movement occurs no movement occurs resting sitting standing watching TV

**Pain radiates to:** neck middle back upper extremities lower back lower extremities

**Pain is worse in the:** morning afternoon evening

**Activities of Daily Living - Difficulties:** Child Care Computer Dancing Eating Sleeping  
Walking Yard Work Shopping Sexual Intercourse Hobbies Sporting Activities Household  
Duties Play with Child Driving Social Activities Religious Events Gardening Working  
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Reading Hockey Sitting Standing Swimming Up/Down Stairs Vacuuming Washing the  
Car Washing Windows Weeding Weight Lifting Other\_\_\_\_\_

**Other:**

Headache Migraine Balance Loss Blurred Vision Constipation Cramps Deep Chest Pain  
Depression Double Vision Light Headed Memory Loss Shortness of Breath Sensitivity to  
Light Ringing In Ears Hearing Loss Loss of Sleep Fainting Loss of Appetite Heartburn  
Indigestion Nervous Stomach Nausea Gas Diarrhea Fatigue Grind/Grate Teeth

Irregular Heartbeat   Irritability   Limitation of Movement   Nervousness   Numbness   Pins & Needles   PMS   Spasm   Stiffness   Temperature   Tension   Swollen Ankles   Other \_\_\_\_\_

**Family History of Disease** (including cancer, heart disease, stroke or diabetes) and age of any immediate family members (parents or siblings):

Relationship	Cause of death	Age of death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries:

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous injuries, trauma or fractures (please give type and date):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

Nutritional Supplements you are currently taking:

Supplement & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

Allergies: \_\_\_\_\_

## Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

**Childhood**

- |                                   |           |                          |           |
|-----------------------------------|-----------|--------------------------|-----------|
| Repeated/Prolonged Antibiotic Use | ___Y ___N | Inhaler Use              | ___Y ___N |
| Car Accident                      | ___Y ___N | Prescription Medications | ___Y ___N |
| Childhood Illness                 | ___Y ___N | Surgery                  | ___Y ___N |
| Fall/Jump from a Height < 3 feet  | ___Y ___N | Vaccinations             | ___Y ___N |
| Fall/Jump from a Height > 3 feet  | ___Y ___N | Youth Sports             | ___Y ___N |

Head Trauma Y N

Other Traumas (physical or emotional) \_\_\_\_\_

**Teen/Adult**

Alcohol Consumption \_\_\_Y \_\_\_N  
 Repeated/Prolonged Antibiotic Use \_\_\_Y \_\_\_N  
 Car Accident \_\_\_Y \_\_\_N  
 Coffee Drinker \_\_\_Y \_\_\_N  
 Drug Use/Abuse \_\_\_Y \_\_\_N  
 Fall/Jump from a Height \_\_\_Y \_\_\_N  
 Head Trauma \_\_\_Y \_\_\_N  
 Home Environment Stress \_\_\_Y \_\_\_N

Inhaler Use \_\_\_Y \_\_\_N  
 Prescription Medications \_\_\_Y \_\_\_N  
 Smoker \_\_\_Y \_\_\_N  
 Surgery \_\_\_Y \_\_\_N  
 Contact Sports \_\_\_Y \_\_\_N  
 Extreme Sports \_\_\_Y \_\_\_N  
 Workplace Stress \_\_\_Y \_\_\_N  
 Other Traumas (physical or emotional) \_\_\_\_\_

**Please CHECK AND EXPLAIN any of the following you have had in the last 12 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:**

**MUSCULO-SKELETAL: Check and Explain** \_\_\_ Low Back Pain \_\_\_ Pain Between Shoulders \_\_\_ Neck Pain \_\_\_ Arm Pain \_\_\_ Joint Pain/Stiffness \_\_\_ Walking Problems \_\_\_ Difficult Chewing/Clicking Jaw \_\_\_ General Stiffness \_\_\_ Not Applicable

**GENITO-URINARY: Check and Explain** \_\_\_ Painful/Excessive Urination \_\_\_ Discolored Urine \_\_\_ Bladder Trouble \_\_\_ Not Applicable

**CARDIO-VASCULAR- RESPIRATORY: Check and Explain** \_\_\_ Chest Pain \_\_\_ Irregular Heartbeat \_\_\_ Blood Pressure Problems \_\_\_ Heart Problems \_\_\_ Varicose Veins \_\_\_ Ankle Swelling \_\_\_ Stroke \_\_\_ Lung Problems/Congestion \_\_\_ Shortness of Breath \_\_\_ Not Applicable

**NERVOUS SYSTEM: Check and Explain** \_\_\_ Nervous \_\_\_ Numbness \_\_\_ Hearing Difficulty \_\_\_ Forgetfulness \_\_\_ Stress \_\_\_ Fainting \_\_\_ Confusion/Depression \_\_\_ Dizziness \_\_\_ Paralysis \_\_\_ Cold/Tingling Extremities \_\_\_ Convulsions \_\_\_ Not Applicable

**EYES, EARS, NOSE, THROAT: Check and Explain** \_\_\_ Vision Problems \_\_\_ Dental Problems \_\_\_ Sore Throat \_\_\_ Ear Aches \_\_\_ Stuffed Nose \_\_\_ Not Applicable

**GENERAL: Check and Explain** \_\_\_ Fatigue \_\_\_ Allergies \_\_\_ Headaches \_\_\_ Fever \_\_\_ Not Applicable

**MALE / FEMALE: Check and Explain** \_\_\_ Menstrual Irregularity \_\_\_ Menstrual Cramps \_\_\_ Vaginal Pain/Infection \_\_\_ Breast Pain/Lumps \_\_\_ Prostate/Sexual Dysfunction \_\_\_ Not Applicable Other: \_\_\_\_\_

**GASTRO-INTESTINAL: Check and Explain** \_\_\_ Excessive Thirst \_\_\_ Frequent Nausea \_\_\_ Vomiting \_\_\_ Black/Bloody Stools \_\_\_ Poor/Excessive Appetite \_\_\_ Constipation \_\_\_ Hemorrhoids \_\_\_ Colitis \_\_\_ Liver Problems \_\_\_ Gall Bladder Problems \_\_\_ Weight Trouble \_\_\_ Abdominal Cramps \_\_\_ Diarrhea \_\_\_ Heartburn \_\_\_ Gas/Bloating after Meals \_\_\_ Not Applicable

**Please check and explain any of the following illnesses you have ever had:** \_\_\_ Cancer \_\_\_ Diabetes \_\_\_ Mental Disorders \_\_\_ Pneumonia \_\_\_ Heart Disease \_\_\_ Rheumatic Fever \_\_\_ Small Pox \_\_\_ Pleurisy \_\_\_ Polio \_\_\_ Chicken Pox \_\_\_ Arthritis \_\_\_ Tuberculosis \_\_\_ Epilepsy \_\_\_ Anemia \_\_\_ Measles \_\_\_ Whooping Cough \_\_\_ Mumps \_\_\_ Thyroid Disorder \_\_\_ Not Applicable

**Which best describes your reason for consulting our office?**

- \_\_\_ I have a specific concern and require help with this concern.
- \_\_\_ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- \_\_\_ I want to be healthier five years from now than I am today.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

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