

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 _____ Home 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 Chiropractic One of Clermont, 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 Chiropractic One of Clermont, 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 Chiropractic One of Clermont, 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.

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

Have you ever?

Yes No

- | | |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> | Been Knocked Unconscious? |
| <input type="checkbox"/> <input type="checkbox"/> | Used Crutches or other Support? |
| <input type="checkbox"/> <input type="checkbox"/> | Been Treated for Spine Problems? |
| <input type="checkbox"/> <input type="checkbox"/> | Been Treated for any Nerve Disorder? |
| <input type="checkbox"/> <input type="checkbox"/> | Had a Fractured/Broken Bone? |
| <input type="checkbox"/> <input type="checkbox"/> | Had Surgery? |
| <input type="checkbox"/> <input type="checkbox"/> | 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:

- | | | |
|--------------------------|---------|------------------------------|
| <input type="checkbox"/> | Alcohol | If yes how often? _____ |
| <input type="checkbox"/> | Coffee | How many cups per day? _____ |
| <input type="checkbox"/> | Tobacco | How many pack per day? _____ |

Is there a Family History of?

- | | | | |
|--------------------------|---------------|--------------------------|-----------|
| <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | Stroke | <input type="checkbox"/> | _____ |

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: _____

Assessment of Activities of Daily Living

Patient Name: _____

Standing

- Able to stand as long as desired without pain
- Able to stand for 60 minutes without pain
- Able to stand for 45 minutes without pain
- Able to stand for 30 minutes without pain
- Able to stand for 25 minutes without pain
- Able to stand for 15 minutes without pain
- Able to stand for 10 minutes without pain
- Able to stand for 5 minutes without pain
- Unable to stand at all due to pain

Bending

- Able to bend as far as would like without pain
- Able to bend 80 degrees without pain
- Able to bend 70 degrees without pain
- Able to bend 60 degrees without pain
- Able to bend 50 degrees without pain
- Able to bend 40 degrees without pain
- Able to bend 30 degrees without pain
- Able to bend 20 degrees without pain
- Able to bend 10 degrees without pain
- Unable to bend at all due to pain

Driving

- Able to drive when necessary without pain
- Able to drive for 120 minutes without pain
- Able to drive for 90 minutes without pain
- Able to drive for 60 minutes without pain
- Able to drive for 45 minutes without pain
- Able to drive for 30 minutes without pain
- Able to drive for 20 minutes without pain
- Able to drive for 10 minutes without pain
- Unable to drive at all due to pain

Walking

- Able to walk as far as desired without pain
- Able to walk 2-3 miles without pain
- Able to walk 1 mile without pain
- Able to walk ½ mile without pain
- Able to walk ¼ mile without pain
- Able to walk 1 block without pain
- Able to walk 100 feet without pain
- Able to walk 50 feet without pain
- Unable to walk at all due to pain

Picking up objects

- Able to pick up heavy objects without pain
- Able to pick up 45 pounds without pain
- Able to pick up 35 pounds without pain
- Able to pick up 25 pounds without pain
- Able to pick up 20 pounds without pain
- Able to pick up 15 pounds without pain
- Able to pick up 10 pound without pain
- Able to pick up 5 pounds without pain
- Unable to lift anything due to pain

Sitting

- Able to sit with no pain
- Able to sit 8 hours with no pain
- Able to sit 7 hours with no pain
- Able to sit 6 hours with no pain
- Able to sit 5 hours with no pain
- Able to sit 4 hours with no pain
- Able to sit 3 hours with no pain
- Able to sit 2 hours with no pain
- Able to sit 1 hour with no pain
- Able to sit 30 minutes with no pain
- Unable to sit at all due to pain

Housework

- Able to do housework for 90 min without pain
- Able to do housework for 80 min without pain
- Able to do housework for 70 min without pain
- Able to do housework for 60 min without pain
- Able to do housework for 50 min without pain
- Able to do housework for 40 min without pain
- Able to do housework for 30 min without pain
- Able to do housework for 20 minutes without pain
- Able to do housework for 10 minutes without pain
- Unable to do housework at all due to pain

Headaches

- Having no headaches
- Having 2 headaches per month
- Having 1 headache per month
- Having 1 headaches per day
- Having 5 headaches per week
- Having 3-4 headaches per week
- Having 1-2 headaches per week
- Having constant headaches

Opening Jars

- Able to open any jar without pain
- Able to open very tight jars without pain
- Able to open medium tight jars without pain
- Able to open lightly closed jars without pain
- Unable to open any jar due to pain

Lying down

- Able to lay as long as would like with no pain
- Able to lay for 120 minutes with no pain
- Able to lay for 90 minutes with no pain
- Able to lay for 60 minutes with no pain
- Able to lay for 30 minutes with no pain
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Other: _____

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Other: _____
