HEALING HANDS
WELLNESS AND CHIROPRACTIC CENTER

Patient Intake Form

PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex *(Please Circle)*: Male Female Height: _____ Weight: _____

Social Status *(Please Circle)*: Single Married Widowed Divorced Separated Minor

Age: _____ Birthdate: _____ Social Security #: _____

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

Employer/School Phone: ( ) _____ Is it okay to call here? Y or N

Name of Parent/Guardian of Minor *(if applicable)*: _____

How did you hear about our office? _____

CONTACT INFORMATION

Cell Phone #: ( ) _____ Home Phone #: ( ) _____ Email: _____

Best time and place to reach you: _____

Emergency Contact Name: _____ Relationship: _____

Phone #: ( ) _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Company: _____

Policy ID #: _____ Policy Group #: _____

Is this an HMO or PPO? _____ If HMO, do you have a referral? Y or N Dr.'s Name: _____

Is patient covered by additional insurance? Y or N

Subscriber's Name: _____

Subscriber's Birthdate: _____ Subscriber's Social Security #: _____

Subscriber's Place of Employment: _____

Insurance Company Phone # (on back of card): _____

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CONFIDENTIAL CONSULTATION – CASE RECORD

(Please Print)

Patient Name: _____ *Today's Date:* _____
Have you tried Chiropractic before? □ Yes □ No *When?* _____
Did Chiropractic help? □ Yes □ No *Why did you discontinue care?* _____
_____
Please identify your major complaint: _____
_____
_____
_____
_____
When did it start? _____
Since it began, it has gotten: □ Worse □ Better □ Same *Have you had this before?* □ Yes □ No
When? _____ *Was it resolved and, if so, how?* _____
_____
How did this pain begin? □ Gradual □ Sudden □ Unusual Activity □ Other _____
Describe the pain: □ Numbness □ Tingling □ Weakness □ Sharp □ Dull □ Achy □ Burning
□ Excruciating □ Shooting □ Throbbing □ Cramping □ Stiff □ Other _____
Your pain is: □ Constant □ Comes and goes *Your pain is:* □ Localized □ Generalized □ Radiating
How does it feel at its worse? _____
Made worse by: □ Sitting □ Standing □ Walking □ Bending □ Sleeping □ Lying Down
□ Sneezing □ Coughing □ Bowel Movement □ a.m. □ p.m. □ Other _____
Made better by: □ Sitting □ Standing □ Walking □ Bending □ Sleeping □ Lying Down
□ Sneezing □ Coughing □ Bowel Movement □ a.m. □ p.m. □ Other _____
Any other symptoms? □ Popping □ Grinding □ Giving Out □ Other _____
What have you done for it (e.g. heat, ice, massage, rest)? _____
Have you ever been in an automobile accident? □ Yes □ No *When?* _____
Describe any automobile accidents in terms of impact, such as minor (fender-bender), moderate, or severe (vehicle totaled): _____
Have you ever had any childhood injuries? □ Yes □ No *Describe:* _____
Have you ever had any sports injuries? □ Yes □ No *Describe:* _____
Activities of daily living affected by this pain: □ Dressing □ Grooming □ Occupation □ Housework
□ Recreational Activities/Hobbies □ Family □ Other _____
What is your occupation? _____ *Do you enjoy it?* □ Yes □ No
What would you like to accomplish through Chiropractic care? _____
_____
Do you have any other complaints? _____
_____
_____

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CONFIDENTIAL CONSULTATION – CASE RECORD (cont.)

Do you have any children? □ Yes □ No *Please list the names and ages of your children below:*

_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS:

MUSCULO-SKELETAL
___ Low Back Pain
___ Pain between Shoulders
___ Neck Pain
___ Arm Pain
___ Leg Pain
___ Joint Pain/Stiffness/Swollen
___ Walking Problems
___ Difficult Chewing/Clicking Jaw
___ Broken/Fractured Bones
___ Muscle/Ligament/Tendon Tears

NERVOUS SYSTEM
___ Numbness/Loss of Feeling
___ Paralysis
___ Muscle Jerking
___ Cold/Tingling Extremities
___ Convulsions
___ Dizziness
___ Forgetfulness
___ Confusion
___ Depression
___ Fainting
___ Nervousness
___ Headaches

GENERAL
___ Fatigue
___ Loss of Sleep/Insomnia
___ Irritability
___ Allergies
___ Fever

GASTROINTESTINAL
___ Poor/Excessive Appetite
___ Excessive Thirst
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Weight Trouble
___ Nausea
___ Vomiting
___ Abdominal Pain
___ Gas/Bloating
___ Heartburn
___ Black/Bloody Stool
___ Liver Trouble
___ Gallbladder
___ Difficulty Swallowing

GENITO-URINARY
___ Bladder Trouble
___ Painful/Excessive Urination
___ Discolored Urination
___ Scanty Urination

CARDIO/VASC/RESP
___ Chest Pain
___ Shortness of Breath
___ Difficulty Breathing
___ Heart Problems
___ Lung Problems
___ Ankle Swelling
___ High Blood Pressure
___ Low Blood Pressure
___ Stroke
___ Varicose Veins
___ Persistent Cough
___ Cough Phlegm/Blood
___ Irregular Heart Beat

MALE/FEMALE
___ Prostate Disorder
___ Sexual Dysfunction
___ Irregular Cycles
___ Menstrual Cramps
___ Breast Pain/Lumps
___ Vaginal Pain
___ Vaginal Discharge
___ Other Problems

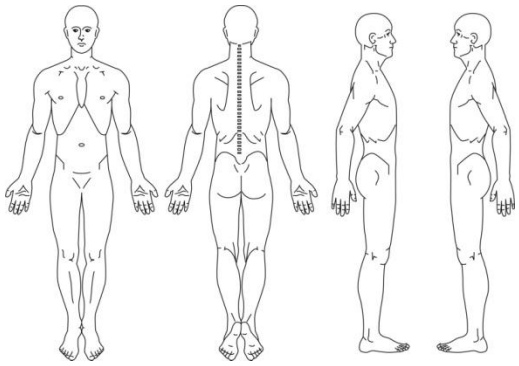
EYES/EARS/NOSE/THROAT
___ Eye Strain/Inflammation
___ Vision Problems
___ Ear Pain/Noises
___ Ear Discharge
___ Hearing Loss
___ Nose Pain/Bleeding
___ Nose Discharge
___ Difficult Nose Breathing
___ Sore Mouth/Gums
___ Dental Problems
___ Sore Throat/Hoarseness
___ Difficult Speech

FAMILY HISTORY
The following members have the same or similar problem as I:
___ Mother
___ Father
___ Sister(s)
___ Brother(s)
___ Child/Children
___ Spouse
___ Aunt
___ Uncle
___ Other _____

The following runs in my immediate family:

___ Cancer
___ Diabetes
___ Stroke
___ Heart Disease
___ High Blood Pressure
___ Back Problems
___ Arthritis
___ Headaches
___ Scoliosis
___ Other _____
_____

PLEASE MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN, NUMBNESS, OR TINGLING:



Patient Signature: _____

Printed Name: _____

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CONFIDENTIAL CONSULTATION – CASE RECORD (cont.)

Patient Name: _____ **Date:** _____

Primary Care Physician _____ **City:** _____

*Can Healing Hands contact your PCP regarding your current conditions and treatment? □ Yes □ No

Current Medication: Please list the names and dosages, if possible.
(include all vitamins, herbal supplements and over-the-counter medications)

_____ _____
_____ _____
_____ _____

Allergies (foods, medications, other substances)**:** Please list and state the reaction you had.

_____
_____

Hospitalizations/Surgeries: Please list procedures, dates and locations.

_____
_____
_____

Previous Injuries (sprains, fractures, auto, head injuries, falls, dislocations, etc.):

_____
_____
_____

Personal Habits: Rate your answer on a scale from 1 to 5 with 1 being No/Never and 5 being Yes/Often
(please answer honestly – all information is confidential)

	Circle your response:		
Exercise Regularly (3-4x per week)	1 2 3 4 5	Use Recreational Drugs	1 2 3 4 5
Wear Seat Belt	1 2 3 4 5	Drink Alcohol	1 2 3 4 5
Drink Coffee/Caffeinated Drinks	1 2 3 4 5	Smoke	1 2 3 4 5
Experience Stress	1 2 3 4 5	Chew Tobacco	1 2 3 4 5
Other _____	1 2 3 4 5		

Nutritional Information: Please describe what you eat and drink in a typical day (breakfast/lunch/dinner/snacks)

_____
_____

Women Only:

Mentrual Period: Age of onset: _____ Regular: Y or N Length of period: _____ days
Date last period began: _____ Average cycle length: _____ days
Difficulty with periods: Y or N Specify: _____
Age at menopause onset (if applicable): ____ Date of last pap smear/pelvic exam? _____
Number of children: _____

Are you currently pregnant? Y or N **Is there any chance you may be pregnant? Y or N**

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