

Patient Intake Form

For Office Use Only Date: _____ Acct #: _____
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Please Print

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Married Single Widowed Divorced Separated Partnered Minor

Date of Birth: _____ Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail Address: _____

Employer: _____ Occupation: _____ # of years: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Date of Birth: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Physician: _____ May we contact them? _____

Whom may we thank for referring you to our office? _____

Briefly describe the reason for your visit or describe your accident or injury: _____

If your reason is due to an injury or accident please continue below, if not go to the next page...

Are your present problems due to an injury? Yes No Enter the date of the injury: _____

Was the injury? Job Related Auto Accident Personal Injury Other: _____

Has the accident been reported? Yes No If so, to whom? To Employer Auto Carrier Other: _____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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List any tests, studies or medications received for this condition:

Tests/Studies: _____

Medications: _____

Were you admitted to the hospital due to this condition: Yes No

If yes, what hospital? _____ Transported by? Ambulance Police Other: _____

Date Admitted: _____ Date Released: _____ Length of Stay: _____

List the hospital procedures received: _____

List symptoms you are experiencing today:

Choose the severity level associated with each symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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Do you suffer from any condition other than that for which you are now consulting us? Yes No

If yes please explain: _____

Do you have any current work restrictions due to this condition?

Off work: Yes No Previously From: _____ To: _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

What type of work do you do? _____

FAMILY AND SOCIAL HISTORY

HABITS

Smoking Packs/day: _____

Alcohol Cups/day: _____

Coffee Cups/Day: _____

Soft Drink Cups/Day: _____

Water Cups/Day: _____

EXERCISE

None

Moderate

Daily

Type: _____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? Yes No

If yes, which ones?: _____

Have you taken any medications in the past? Yes No If yes, which ones?: _____

Do you have any allergies? Yes No If yes, please explain: _____

Have you ever had any surgeries? Yes No (If yes, please enter the approximate date of surgery.)

OPERATIONS AND PROCEDURES

DATE

_____ Back Operation

_____ Female Organs

DATE

_____ Hernia

_____ Thyroid

DATE

_____ Gall Bladder

_____ Stomach

Other _____

Have you ever had X-rays or MRI's taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays or MRI's taken? _____

HEALTH HISTORY

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	RESPIRATORY
<input type="checkbox"/> Allergy	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Deafness	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chills (Constant)	<input type="checkbox"/> Constipation	<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> Fainting	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Frequent Colds	GENITO-URINARY
<input type="checkbox"/> Headache	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Numbness or Pain in arms/legs/hands	<input type="checkbox"/> Heart Burn	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Prostate Trouble (men)
	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Tonsillitis	
MUSCLES & JOINTS	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR FEMALES ONLY
<input type="checkbox"/> Backache	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Cramps
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Dryness	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Hernia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Eczema	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Pain between Shoulders	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Hives or Allergy	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Painful Tailbone	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Itching	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Rapid Heart	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Are You Pregnant?
<input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> Slow Heart	<input type="checkbox"/> Skin Eruptions	
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Strokes		
<input type="checkbox"/> Tremors	<input type="checkbox"/> Swelling Ankles		
<input type="checkbox"/> Twitching	<input type="checkbox"/> Varicose Veins		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | | | |
|---------------------------------------|--------------------------------------|--|------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV Positive |
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I hereby authorize and direct Douglas Chiropractic Center and Dr. Bryan Douglas, DC to provide chiropractic treatment including examination/diagnostics, spinal adjustment, various modes of physical therapy, and any additional procedures or services that may be deemed necessary or reasonable to treat my condition.

Patient's/Guardian's Signature: _____ **Date:** _____