Patient Intake Form

For Office Use Only
Date: ____________________
Acct #:___________________

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		**EXERCISE**	**FAMILY HISTORY**				
				Diabetes	Cancer	Back Pain	Other
❑Smoking	Packs/day: _____	❑None					
❑Alcohol	Cups/day: _____	❑Moderate	Mother	❑	❑	❑	❑_________
❑Coffee	Cups/Day: _______	❑Daily	Father	❑	❑	❑	❑_________
❑Soft Drink	Cups/Day: _____	Type: _________	Brother(s)	❑	❑	❑	❑_________
❑Water	Cups/Day: _______	_______________	Sister(s)	❑	❑	❑	❑_________

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		**DATE**		**DATE**	
_______________	Back Operation	_______________	Hernia	_______________	Gall Bladder
_______________	Female Organs	_______________	Thyroid	_______________	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

- ❑ Allergy
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble (men)

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain between Shoulders
- ❑ Painful Tailbone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors
- ❑ Twitching

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Are You Pregnant?

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

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

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: _____