NORTH COUNTRY CHIROPRACTIC

Patient Intake Information

The following information is needed for our files so we can better serve you.
Please fill in all appropriate portions of the form. If you need help, please ask the receptionist.

Today's Date: _____ Full Name: _____

Home #: _____ Work #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Sex: M F Email: _____

Marital Status: ☐S ☐M ☐CU ☐D ☐W Social Security #: _____

Birthdate: _____/_____/_____ Occupation: _____

Employer: _____

Name & Address of Primary Care Physician: _____

_____

Who may we thank for referring you to our clinic? _____

Have you had previous chiropractic care? ☐No ☐Yes. With whom and when?

_____

Age of mattress: _____ ☐Comfortable ☐Uncomfortable

Please continue on the other side

Please answer the following questions, all of which will help us better assess your condition.

What is your major complaint? _____

_____

When did this condition start? _____ Were you at work? ☐Yes ☐No

How did it happen? (describe in your own words) _____

_____

_____

Have you had this condition in the past? ☐No ☐Yes. Please describe when and what treatment you had

_____

_____

Please mark the diagram with the appropriate symbols to describe your pain/sensations:

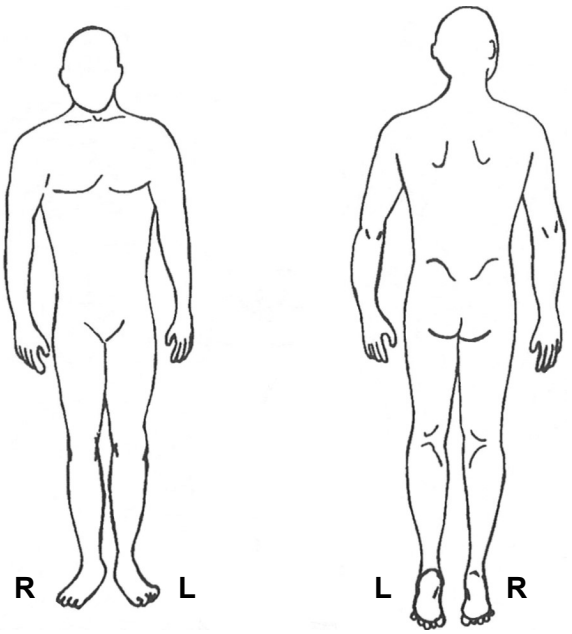
Numbness = = = =

Burning x x x x x
x x x x x

Stabbing / / / / /
/ / / / /

Pins and Needles o o o o o
o o o o o

Aching A A A A A
A A A A A



Rate pain on a scale of 0-10
with 0 being no pain and 10 the worst pain ever _____

Please check all appropriate boxes for questions below.

Is this condition getting progressively better? ☐Yes ☐No

Is this condition getting progressively worse? ☐Yes ☐No

Is it better ☐ in the morning, ☐ at night, ☐ as the day goes on?

Is it worse ☐ in the morning, ☐ at night, ☐ as the day goes on?

What is the frequency of pain?

☐ None ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occassionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What makes your symptoms worse?

☐Coughing	☐Sneezing	☐Sitting	☐Getting up from sitting
☐Walking	☐Lifting	☐Standing	☐Bending
☐Twisting	☐Ice	☐Heat	☐Any movement

☐Other _____

What relieves your symptoms?

☐Ice	☐Heat	☐Movement	☐Bed rest
☐Exercise	☐Stretching	☐Medication (type) _____	

☐Other _____

What are your expectations regarding this condition?

☐Become pain free ☐Explanation of my condition ☐Learn how to care for this condition on my own
☐Reduce symptoms ☐Resume normal activity

What treatment have you had for this condition? (Starting with initial treatment and ending with the most recent)

_____

_____

Have you had any x-rays for this condition? ☐No ☐Yes. Please list where and when _____

_____

_____

Do you have a pacemaker or any implants/hardwear in your body? ☐No ☐Yes. Where?_____

Check any illness or conditions you have had:

☐Diabetes	☐Glaucoma	☐Heart Trouble	☐STD
☐Thyroid	☐Vein Trouble	☐Cancer	☐Asthma
☐Jaundice	☐Bleeding Tendencies	☐Tuberculosis	☐Osteoporosis/Osteopenia
☐Pneumonia	☐Stroke/Seizures	☐Kidney Disease	☐Rheumatic fever
☐Nervous Disorder	☐MS	☐TIA	☐Other

Describe briefly _____

Have you had any serious injuries, trauma, broken bones, etc? ☐No ☐Yes. Please list _____

_____

List previous operations and dates (approximate if necessary) _____

_____

_____

Have you taken cortisone – type (Prednisone) or anticoagulant (Heparin, Coumadin) drugs in the past?

☐No ☐Yes. If yes, what and for how long? _____

_____

Do you have any know drug sensitivities? ☐No ☐Yes. Please list _____

_____

Name, or otherwise identify medicines now or recently used and for what condition _____

_____

_____

_____

_____

Have you experienced any unexplained weight loss/gain in the last 6 months? ☐No ☐Yes. How much?_____

_____

Do you ever get dizzy, nauseous, light-headed or have blurred vision upon turning your head? ☐No ☐Yes

Do you smoke? ☐No ☐Yes. How many packs a day? _____

Do you use alcohol? ☐Never ☐Occasionally ☐Frequently. How much? _____

Do you exercise? ☐No ☐Yes. How often? _____

Please continue on the other side

Do you wear any lifts or supports in your shoes? ☐No ☐Yes. What type? _____

_____

Has anyone in your family had cancer, heart problems, diabetes, spinal problems/surgery, kidney disorders, stroke, tuberculosis, rheumatic fever, or other serious illness?

Father _____

Mother _____

Sisters _____

Brothers _____

Maternal (mother's mother) Grandmother _____

Maternal (mother's father) Grandfather _____

Paternal (father's mother) Grandmother _____

Paternal (father's father) Grandfather _____

Are there any stressful situations currently affecting your quality of life? ☐No ☐Yes

Describe briefly _____

_____

Women only:

Are you or might you be pregnant? ☐No ☐Yes

Last menstrual period _____

Are you now taking ☐, Or have you ever taken ☐ birth control pills? If yes, when and for how long?

_____