CRAWFORDCHIROPRACTIC

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment. Please complete to its entirety.

Who do we have to thank for referring you to us?

_____

Emergency Contact Name & Phone #:

_____

Social Security- _____

Insurance: _____

Primary Insured Name: _____

Primary Insured Date of Birth: _____

Name:_____ **Date:**_____

Date of Birth: _____ **Age:** _____

Height: _____ **Weight:**_____ □ **male** □ **female**

Address: _____ **Marital status**

_____

S	M	W	D	SEP

Phone #: Home:_____

Phone #: Cell:_____ **Carrier:** _____

By providing my carrier, I authorize my doctor to contact me via the provided cell phone number via text or phone call, for appointment reminders and other clinic information.

E-mail address:_____

By providing email address, I authorize my doctor to contact me via the provided email address(es).

Occupation: _____ **Employer:**_____

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

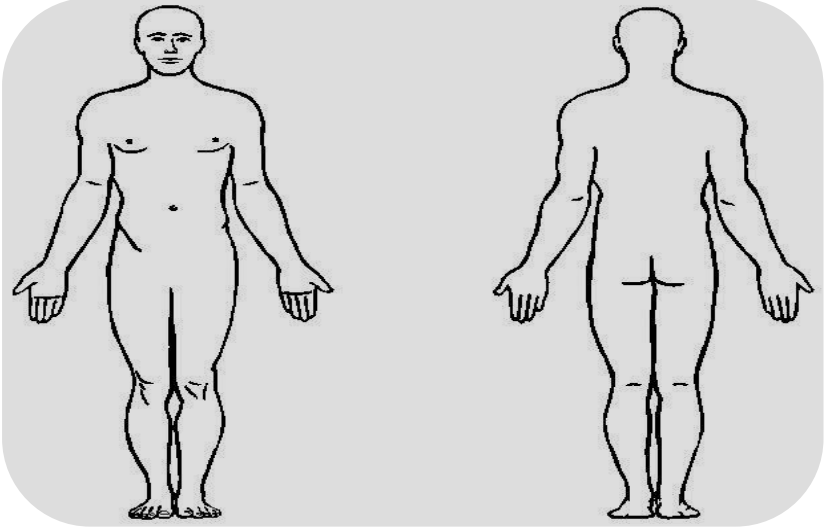
What seemed to be the initial cause: _____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you at (check appropriate box): □ work, □ sleep, □ other: _____

Have you had an recent X-rays, CTs, MRIs, etc. and where?_____

PLEASE MARK YOUR AREA(S) OF PAIN ON THE FIGURE BELOW



Past/Recent Medical History

Have you been hospitalized in the last 2 years?

_____

_____

How is most of your day spent (standing, sitting, walking, etc.)?_____

How old is your mattress?_____

How old is your pillow?_____

Who is your Primary Care Physician and when was your last visit?_____

TELL US A LITTLE MORE ABOUT YOUR PAIN:

Body Part	Pain Level	Frequency Pain Effects You		
HEAD/NECK/UPPER BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50%	50-75%	75-100%
MID - BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50%	50-75%	75-100%
LOWER BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50%	50-75%	75-100%
OTHER:	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50%	50-75%	75-100%
OTHER:	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50%	50-75%	75-100%

Check ☑and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint / Bone
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain
- ☐ Broken bones
- ☐ Major sprains/strains
- ☐ Orthotics

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision Problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ **Pace maker**
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause

Menstrual flow -
- ☐ Reg. ☐ Irreg. ☐ Pain / cramps

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have and ages? _____

_____

General Conditions:
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication (including minerals, vitamins, and/or herbs) you are currently taking and why or we can make a copy of a list you personally carry:_____

_____

_____

_____

_____

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history: ***If any blood relative has had any of the following conditions, please check and indicate which relative(s):***

□ Anemia	□ Bleed easily	□ Epilepsy	□ High cholesterol
□ Arteriosclerosis	□ Cancer	□ Glaucoma	□ Multiple sclerosis
□ Arthritis	□ Diabetes	□ Heart disease	□ Osteoporosis
□ Asthma	□ Emphysema	□ High blood pressure	□ Stroke

Do you have any other health issues or concerns that our staff should be made aware of (surgeries, chronic illnesses, etc)?_____

_____

Signature- _____ Date-_____