SSP Family Chiropractic

Date:_____

Patient Intake Form

Patient Full Name: _____

Street Address: _____Apt #_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone:_____

Work Phone: _____ Email:_____

Date of Birth: _____ Gender: M F T Prefer not to say

Marital Status: _____ Spouse's Name:_____

Number of children and ages: _____

Employer/School Name:_____ Occupation: _____

Name & Number of Emergency Contact:_____

Relationship: _____

Insurance and Payment Information:

Will you be using your insurance? **Y N**

How did you hear about if referral tell us who? _____

Medical information:

Height: _____ Weight:_____Blood Pressure:_____

Health History:

Have you had any surgeries? **Y N** If yes, for what and when?

Are there any past illnesses or conditions we should be aware of?

Do you have a past history of accidents or trauma?

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Do you have a family history of diabetes, cancer, hypertension or progressive neurological diseases that we should be aware of? **Y N**

Allergies, Medications, Supplements Please list with dosages:

ALLERGIES	MEDICATIONS (and reason for taking them)	SUPPLEMENTS

Please check the box beside any condition you have or have had in the past:

- ☐ Muscles, Joints or Bones
- ☐ Nerves, Headaches, Dizziness or Emotional Balance
- ☐ Head, Eyes, Ears, Nose or Throat
- ☐ Heart, Blood Pressure or Circulation
- ☐ Shortness of Breath, Coughing, Asthma or Lung Conditions
- ☐ Stomach, Bowels, or Digestive Conditions
- ☐ Genital, Bladder, or Urinary Conditions
- ☐ Diabetes, Thyroid or Glandular Conditions
- ☐ Skin or Bleeding Conditions
- ☐ Allergies or Sensitivities

If you answered yes to any of the above, please explain:

For Women only:

Are you pregnant? **Y N** Are you nursing? **Y N**

Are you using birth control or taking oral contraceptives? **Y N**

Which one?_____

Do you experience painful periods or irregular cycles? **Y N**

Date of your last menstrual period (if still menstruating)? _____

Do you perform regular self – breast examination? **Y N**

Do you have breast implants? **Y N** When were they implanted? _____

Do you take hormone replacement therapy HRT? **Y N**

When was your last Pap/pelvic exam? _____

When was your last mammogram? _____

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Current work status: Check what applies:

- ☐ *Permanently full disabled*
- ☐ *Permanently partially disabled*
- ☐ *Cannot work due to current condition*
- ☐ *Full time (30-40 hours a week)*
- ☐ *Part time (1-29 hours a week)*
- ☐ *Retired*
- ☐ *Student*
- ☐ *Homemaker*
- ☐ *Unemployed*

Personal habits:

Do you smoke or vape? **Y N** How much? _____

Drink alcohol **Y N** How much per week? _____

Drink caffeine **Y N** Per day number of: Cups of coffee? _____ Energy drinks? _____

Use recreational drugs (circle one) **Y N Occasionally**

Present Exercise Habits: Check what applies

- ☐ *Not currently exercising*
- ☐ *Exercise daily*
- ☐ *Other*
- ☐ *Exercises 3x a week*
- ☐ *Cannot exercise due to condition*

Diet and Nutrition Habits: (Check all that)

- ☐ *Paleo*
- ☐ *Vegan*
- ☐ *Vegetarian*
- ☐ *Keto*
- ☐ *Daily supplements*
- ☐ *Low sugar*
- ☐ *Low salt*
- ☐ *Low Fat*
- ☐ *Kosher*
- ☐ *Diabetic*
- ☐ *Low Fat*
- ☐ *Soft Diet*
- ☐ *Renal*

Other: _____

How can we help you?

Reason for your visit today? _____

Approximate date that your condition began. _____

What do you think caused this condition? _____

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What terms describe your discomfort best? (Choose all that apply)

☐ *Aching* ☐ *Burning* ☐ *Deep* ☐ *Dull* ☐ *Intolerable* ☐ *Sharp*

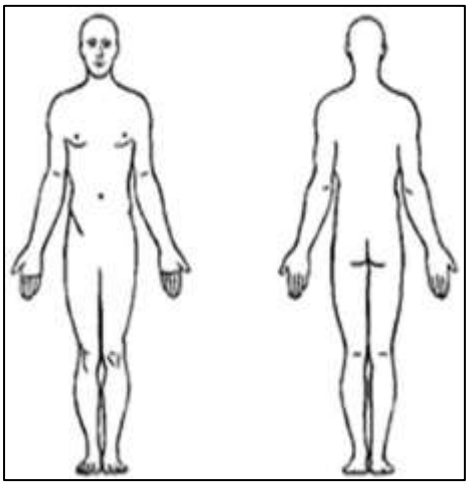
☐ *Shooting* ☐ *Stabbing/Throbbing* ☐ *Stiffness* ☐ *Tightness* ☐ *Tingling*

Please circle your severity of the discomfort at its worst, on a scale of 1-10 where 1 is the least severe and 10 is the most severe.

1----------2----------3----------4----------5---------6---------7---------8----------9----------10

LOCATION OF SYMPTOMS:

Please circle areas on the image where you have discomfort or other symptoms



How often do you feel this discomfort?

_____

How has this complaint changed since the onset?

_____

What activity, if any, is most significantly affected by this discomfort?

- Any movement **Y N**
- Athletic activity and/or exercise **Y N**
- Bending **Y N**
- Carrying or lifting any objects **Y N**
  Or a certain weight? _____
- Changing positions **Y N**
- Daily child or pet care **Y N**
- Household chores (cleaning, cooking, etc.) **Y N**
- Looking over shoulder **Y N**
- Lying down, getting and staying asleep **Y N**
- Pushing, Pulling, Reaching **Y N**
- Raising arm(s) above shoulder(s) **Y N**
- Self-Care (dressing, bathing, etc.) **Y N**
- Sitting in car or chairs **Y N**
  For how long before symptoms flare_____
- Squatting or bending **Y N**
- Standing **Y N**
- Stress **Y N**
- Walking or running **Y N**
- Working at a desk or a computer **Y N**
- Yardwork **Y N**
- Other **Y N**

What improves your condition or gives your relief?

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Have you received any treatment for this issue? **Y N**

If YES, what?

- ☐ OTC medications:_____
- ☐ Prescribed medications _____
- ☐ Natural/Holistic Treatments
- ☐ Acupuncture
- ☐ Massage
- ☐ Chiropractic Care
- ☐ Medical injection treatments
- ☐ Surgical treatments _____
- ☐ Physical Therapy
- ☐ Other:_____
  _____

Have you had any other health care providers perform tests related to this condition? **Y N**

If Yes:

By Who? _____What tests: _____

Have you ever had any previous episodes of this condition? **Y N**

Does anything else bother you?_____

I realize that this information is subject to the laws of HIPAA and will be kept confidential.
I have been shown a copy of the HIPAA laws.

Please initial _____

All appointments are important to you and to Dr. Julie. To provide the best care to you and to others of the clinic; we ask that you respect your appointment. If you have a problem with your time and date, please respect each person that Dr. Julie sees and reschedule as soon as possible, 24 hours would be extremely helpful. If you are a new patient AND you do not show for your appointment, you will be charged a flat fee of $40 dollars for missing your appointment.

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Signature Date