Marty Chiropractic New Patient Intake

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male ○ Transgender ○ Non-binary
○ Prefer not to respond

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City _____ State: _____

Zip Code: _____ Mobile Phone: _____ Home Phone: _____

Email: _____ Occupation _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Emergency Contact _____

Relationship _____ Phone # _____

2. Referral Information

How did you find out about us?

_____

Primary Care Physician (Name & Location)

_____

3. What is the purpose of your visit?

_____

4. What is your primary complaint?

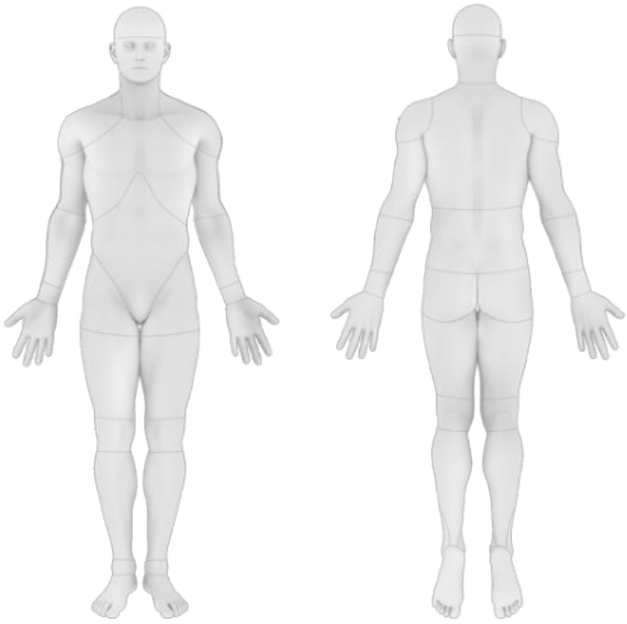
_____

_____

_____

_____

5. Location of discomfort: mark on the diagram where your complaint is located



6. What caused the onset? And when did it start?

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7. Does the complaint radiate or travel?

- ○ Yes
- ○ No

8. If so, where?

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9. Timing and Duration

Since the onset of your complaint how has it been changing?
☐ Getting better ☐ Not changing ☐ Getting worse

How often do you experience this complaint?
☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)

Does your complaint worsen? If so, When?
☐ Does not change ☐ Morning ☐ Midday ☐ Night ☐ Sleep ☐ Work ☐ Exercise

How much has the complaint interfered with your normal work? (including work outside the home and housework)
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much would you say this complaint has affected your social activities?
☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

10. Severity

- ○ 0 = No pain
- ○ 1 = Minimal
- ○ 2 = Very Mild
- ○ 3 = Mild
- ○ 4 = Mild to Moderate
- ○ 5 = Moderate
- ○ 6 = Moderate to Severe
- ○ 7 = Mildly Severe
- ○ 8 = Severe
- ○ 9 = Very Severe
- ○ 10 = Excruciating

11. Quality: How would you describe the sensation of your complaint?

- ☐ Sharp Pain
- ☐ Dull Ache
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Numbness
- ☐ Tingling
- ☐ Tightness
- ☐ Pulling
- ☐ Other

12. Modifying Factors: What makes your complaint feel worse? (list)

_____

_____

_____

_____

13. Alleviating Factors: What makes your complaint feel better? (list)

_____

14. Previous Treatment

Who have you seen for this condition?

☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ None ☐ Other

Have you had chiropractic care in the past?

☐ Yes ☐ No

If so, when?

_____

15. Risk Factors

Do you have a pace maker?

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No ☐ Maybe

Do you have any metal implants or devices?

☐ Yes ☐ No

16. History was obtained from?

☐ Patient ☐ Parent ☐ Guardian ☐ Child ☐ Other

17. Current Health

Health concerns, if any:	Yes	No
Muscles, Bones or Joints		
Nerves, Headache, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Shortness of Breath, Coughing, Asthma or Lund Condition		
Genital, Bladder or Urinary		
Diabetes, Thyroid or Glandular Conditions		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

If yes, please list here:

_____

18. Personal and Family History

	Yes	No
Have you had any surgical procedures?		
Are there any past illnesses or conditions we should be aware of?		
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?		

If yes, please list here:

_____

19. Current Work Habits

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-Time (20-40+ hours/week)
- ☐ Part-Time (1-19 hours/week)
- ☐ Retired
- ☐ Student
- ☐ Homemaker
- ☐ Unemployed

20. Present Exercise Habits

- ○ No current exercises
- ○ Exercises daily
- ○ Exercises 3+ times per week
- ○ Cannot exercise due to current condition
- ○ Other, to be discussed with doctor

21. Personal Social Habits

	Yes	No
Smoke or use tobacco products		
Drink Alcohol		
Drink Caffeine		
Use Recreational Drugs		
Do you sleep well?		
Other, to be discussed with doctor		

22. Diet and Nutrition Habits

	Yes	No
Vegan		
Vegetarian		
Daily supplements		

23. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

24. Secondary Insurance

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other