Schone's Chiropractic, P.C.

PATIENT INTAKE & HISTORY

Name: ______________________ Employer: ______________________

Address: ______________________ Type of Work: ______________________

City/State/Zip: ______________________ Have you seen a Chiropractor before? __________

Home Phone: ______________________ If yes, when? ______________________

Cell Phone: ______________________ Who Referred You? ______________________

Email: ______________________ Know anyone who comes here? __________

Sex: ______ Age: _____ DOB: __________ Emergency Contact: ______________________

Social Security #: ______________________ Emergency Contact Phone #: __________

Significant Other/Spouse: ______________________ Medical Doctor: ______________________

1. Main Complaint: ______________________ How long? __________

Describe your Pain: ❑ Aching ❑ Burning ❑ Cramping ❑ Deep ❑ Dull ❑ Numb ❑ Radiating ❑ Sharp ❑ Stabbing ❑ Stiff ❑ Swelling ❑ Tight ❑ Tingling ❑ Throbbing ❑ Sore ❑ Shooting

Frequency of Pain: ❑ Intermittent ❑ Occasional ❑ Frequent ❑ Constant

Aggravating Factors: ❑ Nothing ❑ Movement ❑ Bending ❑ Carrying Things ❑ Coughing ❑ Driving ❑ Eating ❑ Exercise ❑ Stairs ❑ Heat ❑ Housework ❑ Ice ❑ Jogging ❑ Lifting ❑ Laying Down ❑ Pushing ❑ Pulling ❑ Sitting ❑ Sleeping ❑ Standing ❑ Squatting ❑ Stress ❑ Stretching ❑ Taking a Deep Breath ❑ Turning ❑ Twisting ❑ Walking ❑ Working

Relieving Factors: ❑ Nothing ❑ Anti-Inflammatories ❑ Bracing ❑ Chiropractic Care ❑ Elevation ❑ Exercise ❑ Heat ❑ Ice ❑ Massage ❑ Movement ❑ Pain Killers ❑ Rest ❑ Stretching ❑ Walking ❑ Wraps ❑ Sitting ❑ Standing ❑ Bending

Rate your Pain: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What Daily Activities are Affected: ❑ Bathing ❑ Cleaning ❑ Stairs ❑ Laundry ❑ Dressing ❑ Driving ❑ Eating ❑ Exercising ❑ Laying Down to Sitting ❑ Sitting to Standing ❑ Grooming ❑ Housework ❑ Laying Down ❑ Lifting ❑ Sitting ❑ Sleeping ❑ Social/Recreational Activities ❑ Standing ❑ Stretching ❑ Transferring ❑ Walking ❑ Watching TV ❑ Working ❑ Yard Work

Have you been given a diagnosis for this problem? If yes, when were you diagnosed and what was the diagnosis given? ______________________

Balanced Weights (Office Use Only)

L __________ R __________

Are you pregnant?

❑ Yes ❑ No

1. Secondary Complaint: ______________________________________ How long? ____________________

Describe your Pain: ❑ Aching ❑ Burning ❑ Cramping ❑ Deep ❑ Dull ❑ Numb ❑ Sore
❑ Radiating ❑ Sharp ❑ Stabbing ❑ Stiff ❑ Swelling ❑ Tight ❑ Tingling ❑ Throbbing ❑ Shooting

Frequency of Pain: ❑ Intermittent ❑ Occasional ❑ Frequent ❑ Constant

Aggravating Factors: ❑ Nothing ❑ Movement ❑ Bending ❑ Carrying Things ❑ Coughing
❑ Driving ❑ Eating ❑ Exercise ❑ Stairs ❑ Heat ❑ Housework ❑ Ice ❑ Jogging ❑ Lifting
❑ Laying Down ❑ Pushing ❑ Pulling ❑ Sitting ❑ Sleeping ❑ Standing ❑ Squatting ❑ Stress
❑ Stretching ❑ Taking a Deep Breath ❑ Turning ❑ Twisting ❑ Walking ❑ Working

Relieving Factors: ❑ Nothing ❑ Anti-Inflammatories ❑ Bracing ❑ Chiropractic Care ❑ Elevation
❑ Exercise ❑ Heat ❑ Ice ❑ Massage ❑ Movement ❑ Pain Killers ❑ Rest ❑ Stretching
❑ Walking ❑ Wraps ❑ Sitting ❑ Standing ❑ Bending

Rate your Pain: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What Daily Activities are Affected: ❑ Bathing ❑ Cleaning ❑ Stairs ❑ Laundry ❑ Dressing
❑ Driving ❑ Eating ❑ Exercising ❑ Laying Down to Sitting ❑ Sitting to Standing ❑ Grooming
❑ Housework ❑ Laying Down ❑ Lifting ❑ Sitting ❑ Sleeping ❑ Social/Recreational Activities
❑ Standing ❑ Stretching ❑ Transferring ❑ Walking ❑ Watching TV ❑ Working ❑ Yard Work

Have you been given a diagnosis for this problem? If yes, when were you diagnosed and what was the diagnosis given? ____

What Treatments have you tried for your condition/s? ❑ None ❑ Medication ❑ Surgery
❑ Chiropractic ❑Physical Therapy ❑ Other ______________________________

Are you presently under the care of a physical/mental health care provider? ____________________

What are your daily Energy Levels like: ❑ Good ❑ Insufficient ❑ Erratic ❑ Low

Low time of day: ____________________ High time of the day: ____________________

Sleep: ❑ Trouble falling asleep ❑ Trouble staying asleep ❑ Restful ❑ Other ______________Stress:
❑ None ❑ Low ❑ Moderate ❑ Severe What causes stress? ______________________

Have you had unexpected weight loss/gain in last 6 months? ❑ No ❑ Yes, how much? ____________

Do you smoke? ❑ Never ❑ Current Smoker ❑ Former Smoker If yes, how much? ______________

How many Caffeinated drinks a day: ❑ None ❑ Unknown ❑ 1-3 ❑ 4-7 ❑ 10+

How many Alcoholic drinks a week: ❑ None ❑ Unknown ❑ 1-5 ❑ 5-10 ❑ 10+

Do you exercise regularly? ❑ No ❑ Yes ❑ Light ❑ Moderate ❑ Heavy

REVIEW OF SYSTEMS

Musculoskeletal: ❑ Back Pain ❑ Feet/Leg Pain ❑ Hip ❑ Knee ❑ Low Back Pain ❑ Mild Back ❑ Muscle/Joint Pain ❑ Neck Pain ❑ Redness of joints ❑ Shoulder Pain ❑ Upper Back Pain

Cardiovascular/Respiratory: ❑ None ❑ Chest Pain ❑ Cold Hands/Feet ❑ Cough Blood ❑ Dizziness ❑ Cough Phlegm ❑ Difficulty Breathing ❑ Fainting ❑ Irregular Heartbeat ❑ Palpitations ❑ Persistent cough ❑ Swelling (edema) ❑ Shortness of Breath ❑ Other ______________________

Head/Neck: ❑ None ❑ Dizziness ❑ Facial Pain ❑ Grinding Teeth ❑ Headache ❑ Head Injury ❑ Jaw Clicks ❑ Lumps ❑ Migraines ❑ Pain ❑ Sore Throat ❑ Stiffness ❑ Swollen Glands ❑ Tooth Problems ❑ Trouble Swallowing ❑ Other ______________________

Eyes: ❑ None ❑ Blurred Vision ❑ Burning ❑ Cataracts ❑ Double Vision ❑ Dryness ❑ Glaucoma ❑ Glasses/Contacts ❑ Flashing Lights ❑ Itching ❑ Pain ❑ Redness ❑ Specks ❑ Vision Problems

Ears: ❑ None ❑ Buzzing in Ears ❑ Decreased Hearing ❑ Drainage ❑ Earache ❑ Ear infections ❑ Poor Balance ❑ Poor Hearing ❑ Ringing in Ears ❑ Other ______________________

Nose: ❑ None ❑ Allergies ❑ Blocked Sinuses ❑ Discharge ❑ Excessive Mucus ❑ Nose Bleeds ❑ Itching ❑ Sinus Pressure/Pain ❑ Stuffiness/Blockage Other: ______________________

Throat/Mouth: ❑ None ❑ Bleeding ❑ Blue Lips ❑ Braces ❑ Dentures ❑ Difficulty Swallowing ❑ Dry Mouth ❑ Hoarseness ❑ Mouth Pain ❑ Non Healing Sores ❑ Sore Throat ❑ Swelling ❑ Thrush

Urinary: ❑ None ❑ Blood in Urine ❑ Burning or Pain ❑ Difficulty Urinating ❑ UTI's ❑ Kidney Stones ❑ Kidney Infections ❑ Frequent Urination ❑ Unable to Hold Urine ❑ Urgency ❑ Water Retention

Gastrointestinal: ❑ None ❑ Change in Appetite ❑ Change in Bowel Habits ❑ Constipation ❑ Diarrhea ❑ Heartburn ❑ Nausea ❑ Rectal Bleeding ❑ Yellow Eyes or Skin (jaundice) ❑ Sweating

Endocrine: ❑ None ❑ Change in Appetite ❑ Cold Intolerance ❑ Constipation ❑ Diarrhea ❑ Dry Skin ❑ Frequent Urination ❑ Heat Tolerance ❑ Sweating ❑ Other ______________________

Vascular/Hematologic: ❑ None ❑ Calf Pain with Walking ❑ Cold Hands and Feet ❑ Ease of Bleeding ❑ Ease of Bruising ❑ Leg Craping ❑ Other: ______________________

Neurologic: ❑ None ❑ Dizziness ❑ Easily Angered/Irritated ❑ Fainting ❑ Frequent Crying ❑ Worry ❑ Anxiety ❑ Poor Concentration ❑ Seizures ❑ Suicidal Thoughts ❑ Tingling ❑ Tremors ❑ Weak ❑ Numbness ❑ Other ______________________

Psychiatric: ❑ None ❑ Anxiety ❑ Depression ❑ Nervous ❑ Stress ❑ Memory Loss ❑ Moody

List any Medications you are taking: ____

____

List any past auto collisions: ____

Was any care received? ____

List any past work injuries: ____

Was any care received? ____

List any past sport, recreational, home injuries: ______________________________

Please list any hospitalizations and surgeries: ______________________________

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Family History: Please list anything pertaining to family history:

Mother: ____

Father: ____

Is there any other family history you would like to share? ______________________

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The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

____ ____________________

Signature of Patient, Parent, Guardian Date: