

Charleston Chiropractic Associates Intake Forms

Patient Information

Patient Name _____ Date _____

Address _____

City

State

Zip

Sex: M F Age _____ Birthday _____ / _____ / _____

Single Married Widowed Separated Divorced

Patient S.S.# _____ - _____ - _____ Home Phone Number _____

Cell Phone Number _____

Email Address _____

Occupation _____

Employer _____ Employer Phone _____

Emergency Contact _____ Phone Number _____ - _____ - _____

Were you referred by anyone? If so, who may we thank? _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching

Shooting Burning Tingling Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

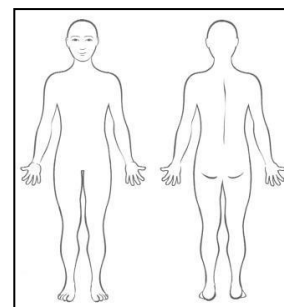
Does it interfere with your

Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking

Bending Laying Down

Mark an X on the picture where you continue to have pain.



Health History

What treatment have you already received for you condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental Exam _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | |
|---------------|--|----------------|--|------------------|--|-----------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple | | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid | |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's | | Tumors, | |
| Bleeding | | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | High | | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal | |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Press. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate | | Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High | | Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Veneral | |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical | | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping | |
| Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic | | Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chick Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | _____ |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking _____ Packs/Day
- Alcohol _____ Drinks/Week
- Coffee/Caffeine Drinks _____ Cups/Day
- High Stress Level _____ Reason _____

Are you Pregnant Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Injuries	_____	_____
Surgeries	_____	_____

Medications

Allergies
