Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form.*** Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Spinal Rehabilitation Center of Lake Geneva
GETTING IT STRAIGHT

Patient Information

Date: _____ **SSN:** _____ **DOB:** _____ **Age:** _____

First Name: _____ **Middle Initial:** _____ **Called Name:** _____ **Last Name:** _____

Sex: ◯M ◯F **Race:** _____ **Ethnicity:** _____ **Height:** _____ **Weight:** _____

Marital Status: ◯S ◯M ◯W ◯D ◯Sep **Spouse Name:** _____ **# Of Children:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Emergency Contact: _____ **Emergency Relation:** _____ **Emergency Phone:** _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed **Employer Name:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Complaint Information

Injury Occurred: ◯Automobile ◯Work ◯Third-Party ◯Other **Injury Date:** _____

Injury Origin: _____

Describe Discomfort: _____

Frequency: ◯Always ◯Hourly ◯Daily ◯Occasionally

Interfere w/ Activities: ◯Yes ◯No **Affected Sleep:** ◯Yes ◯No

Missed Work: ◯Yes ◯No **Unable to Work from:** _____ **Unable to Work til:** _____

Affected Appetite: ◯Yes ◯No Explain: _____

Reduced Work: ◯Yes ◯No Explain: _____

Does it Worsen: ◯Yes ◯No Explain: _____

Weather Affects it: ◯Yes ◯No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯Yes ◯No Explain: _____

X-rays Taken: ◯Yes ◯No Explain: _____

Same Condition Before: ◯Yes ◯No **Date:** _____ **Practitioner:** _____

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing

Have you been adjusted by a chiropractor before? ◯Yes ◯No

If yes, what was the reason? _____

Doctor's Name: _____ **Date of last visit:** _____

Social History & Life Choices

Alcohol:	◯Daily	◯Weekly	◯Occasionally	◯Never	**Caffeine Drinks:**	◯Daily	◯Weekly	◯Occasionally	◯Never
Soft Drinks:	◯Daily	◯Weekly	◯Occasionally	◯Never	**Exercise:**	◯Daily	◯Weekly	◯Occasionally	◯Never
Water:	◯Daily	◯Weekly	◯Occasionally	◯Never	**Tobacco:**	◯Daily	◯Occasionally	◯Past	◯Never

History

List current Medications: _____
(name, length of use, reason for use)

List current vitamins, minerals, supplements, or herbs: _____
(name, length of use, reason for use)

Have you ever:

Broken Bones: ◯Yes ◯No **Treatment:** ◯Yes ◯No Explain: _____

Sprains/Strains: ◯Yes ◯No **Treatment:** ◯Yes ◯No Explain: _____

Hospitalized: ◯Yes ◯No Explain: _____

Surgery: ◯Yes ◯No Explain: _____

Auto Accident: ◯Yes ◯No **Treatment:** ◯Yes ◯No Explain: _____

Struck Unconscious: ◯Yes ◯No **Treatment:** ◯Yes ◯No Explain: _____

Eating Disorder: ◯Yes ◯No Explain: _____

Stroke: ◯Yes ◯No Explain: _____

Family Health History: _____
Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.

Last Physical Exam: _____ **Primary Phys:** _____ **Phys Phone #:** _____

Health Conditions: _____

Health Checklist

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

☐ Allergies	☐ Alcoholism	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis
☐ Asthma	☐ Back Pain	☐ Breast Lump	☐ Bronchitis	☐ Bruise Easily
☐ Cancer	☐ Chest Pain	☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems	☐ Dizziness	☐ Excessive Menstruation
☐ Eye Pain or Difficulties	☐ Fatigue	☐ Frequent Urination	☐ Headache	☐ Hemorrhoids
☐ High Blood Pressure	☐ Hot Flashes	☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance	☐ Loss of Smell	☐ Loss of Taste
☐ Nosebleeds	☐ Pacemaker	☐ Polio	☐ Poor Posture	☐ Prostate Trouble
☐ Sciatica	☐ Shortness of Breath	☐ Spinal Curvatures	☐ Sinus Infection	☐ Insomnia
☐ Swollen Joints	☐ Stroke	☐ Swelling of Ankles	☐ Ulcers	☐ Thyroid Condition
☐ Tuberculosis	☐ Varicose Veins	☐ Venereal Disease	☐ Other: _____	

Women Only

Are you pregnant? ◯Yes ◯No **Are you taking birth control?** ◯Yes ◯No **Do you have irregular cycles?** ◯Yes ◯No

Are you nursing? ◯Yes ◯No **Do you experience painful periods?** ◯Yes ◯No **Do you have breast implants?** ◯Yes ◯No

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh you needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **I want the Doctor to select the type of care appropriate for my condition.**

☐ **Relief Care:** Symptomatic relief of pain or discomfort.

☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

Authorization

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____ Print parent name if under 18: _____

☐ Adult Patient ☐ Parent of Guardian ☐ Spouse