

Austin Lake Chiropractic intake form

PLEASE PRINT

Date: _____

Circle One: Mr. Mrs. Miss Ms.

Name: _____
First Middle Last

Street Address: _____

City: _____ State: _____

Zip: _____ Daytime Phone: _____

Evening Phone: _____ Sex: M F

Birth Date: _____ Age: _____

Social Security #: _____ - _____ - _____

How did you hear about our office? _____

No. of Children: _____

Who is Responsible for your bill, you and:

_____ Spouse _____ Worker's Compensation

_____ Medicare _____ Medicaid

_____ Auto Ins. _____ Parents

_____ Personal Health Insurance

Carrier Name: _____

Your Occupation: _____

Your Employer: _____

Employer's Address: _____

Employer's Phone: _____

Marital Status: S M W D

Spouse's Name: _____

Spouse's Employer: _____

Current Health Condition

Primary Reason for Visit: _____

Other Doctor's seen for this condition: _____

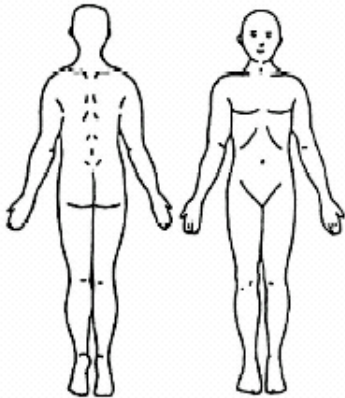
When did this condition begin? _____

What makes this condition worse? _____

What relieves this condition? _____

Are there others in your family with this same condition? Yes No

If Yes, Please provide their name and their relationship to you? Name Relationship



Please Outline on the diagram the area of your discomfort.

Diagram code: N=Numbness P=Pain X=Tenderness

B=Burning T=Tingling M=Muscle Spasm

Is this injury **Work Related**? Yes No If disabled from work please give dates: _____

Is this injury **Auto Related**? Yes No If auto related please indicate date of accident: _____

Medications you now take: o Nerve pills o Pain Killers o Blood Pressure
 o Insulin o Aspirin o Other

OVER →

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Past Health History

Please check or describe

Major Surgery / Operations [] Appendix [] Tonsils [] Gall Bladder [] Hernia [] Heart [] Back [] Neck [] Leg [] C-Section [] Other : _____

Major Accidents or Falls: _____

Hospitalization (other than Above): _____

Have you ever been under Chiropractic Care? [] Yes [] No If Yes? Dr's Name: _____

If, Yes how would you rate your experience? Excellent Good Bad Date of last visit? _____

Have you been treated for any other health condition in the last year? [] Yes [] No

If Yes, Please explain: _____

Is there anything we have not asked that you should tell us? If So, what? _____

How often do you floss your teeth? Daily Occasionally Never

How often do you wear your seatbelt? Always Occasionally Never

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall course of chiropractic care.

Check any of the following diseases you have had:

[] Pneumonia [] Mumps [] influenza [] Rheumatic Fever [] Small Pox [] Pleurisy [] Polio [] Chicken Pox [] Arthritis [] Tuberculosis [] Diabetes [] epilepsy [] Whooping Cough [] Cancer [] Mental Disorder [] Anemia [] Heart Disease [] Lumbago [] Measles [] Thyroid [] Eczema

Intake

Coffee [] Yes [] No _____ Cups/Day Cigarettes [] Yes [] No _____ #/Day Tea [] Yes [] No _____ Cups/Day White Sugar [] Yes [] No Alcohol [] Yes [] No _____ Drinks/Month

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Check any of the following you have had in the past 6 months:

Musculo-Skeletal

- Pain between shoulders
 Low back pain
 Neck Pain
 Arm Pain
 Joint pain/stiffness
 Walking Problems
 TMJ Trouble
 General Stiffness

Nervous System

- Nervousness
 Numbness
 Paralysis
 Dizziness
 Forgetfulness
 Confusion/Depression
 Fainting
 Convulsions
 Cold/Tingling Extremities
 Stress

General

- Fatigue
 Allergies

Loss of Sleep

- Fever
 Headaches

Gastro-intestinal

- Poor/excessive Appetite
 Excessive Thirst
 Frequent Nausea
 Vomiting
 Diarrhea
 Constipation
 Hemorrhoids
 Liver Problems
 Gall Bladder Problems
 Weight Trouble
 Abdominal Cramps
 Gas/Bloating after meals
 Heartburn
 Black/Bloody Stool
 Colitis

Genito Urinary

- Bladder Trouble
 painful/excessive urination
 discolored urine

C-V-R

- Chest Pain
 Short of Breath
 Blood Pressure Problems
 Irregular Heartbeat
 Heart Problems
 Lung Problems/Congestion
 Varicose Veins
 Ankle Swelling
 Stroke

EENT

- Vision Problems
 Dental Problems
 Sore Throat
 Ear Aches
 Hearing Difficulty
 Stuffy Nose

Male/Female

- Menstrual Irregularity
 Menstrual Cramping
 Vaginal Pain/infections
 Breast Pain/Lumps
 Prostrate/Sexual Dysfunction

Females Only:

When was your last period? _____

Are you Pregnant? Yes No Not Sure

Please read the statements below and initial the boxes next to the statements with which you agree:

- I have received the privacy guidelines for Advanced Chiropractic Clinic as per HIPPA requirements.
I certify that information provided to this office is up to date and correct to the best of my knowledge.
I am the authorize parent or guardian of this child, and I authorize this office to treat my child.
I authorize the release of any medical information necessary to process this and future claims submitted to my insurance carrier.
I authorize payment of any medical benefits directly to this chiropractic clinic for any services rendered to me.

Signature of Patient

or authorized guardian _____ Date: _____