REFORM CHIROPRACTIC

PATIENT INTAKE FORMS

Name _____ Date _____

Preferred name (if different) _____ Date of birth _____

Sex (circle): Male Female

Address _____ City _____ State ____ Zip _____

Primary phone number _____ Work # _____

Email address _____ EXT. _____

Would you like appointment reminders? (circle)
Text Email Both No thanks

Emergency Contact (Name/Relationship/Phone) _____

How were you referred? _____

Previous Chiropractic Care? (circle) Y or N When was your last treatment? _____

Ethnicity (circle)
Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Race (circle)
☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaskan Native
☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Native Hawaiian or other Pacific Island ☐ Samoan
☐ Guamanian or Chamorro ☐ Other: _____ ☐ I decline to answer

Electronic Records Waiver

☐ I choose to decline electronic access to my clinical records. *** You may revoke this waiver at any time***

Reform Chiropractic

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Family History

Please check any health conditions of immediate family members below.

	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather	Mother	Father	Sibling	Sibling
Living								
Deceased								
Cancer								
Diabetes								
Heart disease								
Psychological								
Scoliosis								
Stroke								
Thyroid disease								
Multiple sclerosis (MS)								
Rheumatoid arthritis (RA)								

Medical history

Primary care provider: _____

Please list any surgeries:

_____

_____

Please list any past traumas or accidents:

_____

_____

Please list current Illnesses or hospitalizations in the last year:

_____

_____

Please list current medications/why are you taking them:

_____

_____

☐ I am currently not taking any medication.

Please list any medication allergies:

_____

Reform Chiropractic

Name _____ Date _____

What is the reason for your visit? _____

When did symptoms first appear? _____

What this the result of an injury? (Circle) Yes No

Was this the result of a motor vehicle accident? (Circle) Yes No

Was this the result of a work-related injury? (Circle) Yes No

Have you seen any other provider for this yet? (Circle) Yes No

Have you had previous diagnostic testing/imaging for this? (x-ray, MRI, CT, lab tests): Yes No

Social history

Please circle the one that applies: Single Married Divorced Widowed

Employer: _____Occupation: _____

Working Status (circle):
Full time Part time Student Retired Not currently working

Work Activity (circle):
Sitting Standing Light labor Moderate labor Heavy labor

Smoking Status: (Circle)
Daily smoker Occasional smoker Former smoker Never smoker

Other tobacco products: (Circle) Yes No
Please specify if yes: _____

Illegal Drug Use: (Circle) Yes No
Please specify if yes: _____

How many caffeinated beverages do you consume daily? (Circle)
None 1-2 3-4 5-6 >7

Do you exercise? (Circle)
I do not exercise 1-2 days/week 3-4 days/week 5-6 days/week Daily
What type of activity_____

How often do consume alcohol? (Circle)
Never Rarely 1-2x/month 3-4x/month 1-2x/week 3-4x/week Daily

Reform Chiropractic

Name _____ Date _____

Please indicate if you are <u>currently</u> experiencing any of these symptoms on a persistent or frequently recurring basis.

Constitutional	☐ None	☐ chills	☐ fever	☐ night sweats
	☐ daytime drowsiness	☐ fatigue, malaise	☐ loss of appetite	☐ weight gain / loss
Eyes/Vision	☐ None	☐ cataracts	☐ glaucoma	☐ itching
	☐ eye pain	☐ wear contacts or glasses	☐ blurred vision	☐ blindness
	☐ photophobia	☐ change in vision	☐ double vision	☐ tearing
	☐ eye disease, injury, or surgery			
Ears, Nose & Throat	☐ None	☐ ear pain/discharge	☐ dizziness	☐ ringing in the ears
	☐ hearing loss	☐ loss sense of smell	☐ runny nose	☐ nasal congestion
	☐ nose bleeds	☐ sinus problems	☐ sore throat	
	☐ sores in mouth or nose		☐ pain or difficulty swallowing	
	☐ history of head injury			
Respiration	☐ None	☐ cough	☐ coughing blood	☐ coughing phlegm
	☐ wheezing	☐ asthma	☐ COPD	☐ shortness of breath
Cardiovascular	☐ None	☐ high blood pressure	☐ low blood pressure	☐ varicose veins
	☐ murmur	☐ chest pain	☐ palpitations	☐ fainting
	☐ orthopnea (Difficult breathing laying down)	☐ shortness of breath with exertion		☐ claudication (leg pain/ache)
	☐ swelling of feet, ankles and/or hangs			
Gastrointestinal	☐ None	☐ abdominal pain	☐ diarrhea	☐ constipation
	☐ blood in stool	☐ jaundice	☐ liver disease	☐ heartburn
	☐ kidney stones	☐ loss of bowel control		
Endocrine	☐ None	☐ diabetes	☐ liver disease	☐ thyroid issues
	☐ high blood sugar	☐ low blood sugar	☐ unusually thirsty	☐ frequent urination
	☐ heat or cold intolerance			
Female	☐ None	☐ frequent urination	☐ vaginal discharge	☐ irregular menses
	☐ hormone therapy	☐ burning urination	☐ urine retention/incontinence	
	☐ abnormal vaginal bleeding		☐ breast lump/pain, nipple discharge	
	☐ I am currently pregnant			
Male	☐ None	☐ burning urination	☐ frequent urination	☐ penile discharge
	☐ hormone therapy	☐ prostate problems	☐ urine retention/incontinence	
Sexual Health	Do you have any concerns about your sexual health?		☐ Yes	☐ No
	Are you or have you ever been a victim of domestic or sexual abuse?		☐ Yes	☐ No
Skin	☐ None	☐ change in skin color	☐ rash	☐ change in nails
	☐ hair loss	☐ itching	☐ hives	☐ skin lesions/ulcers
	☐ suspicious moles or lesions that won't heal			
Nervous System	☐ None	☐ stroke	☐ weakness of limbs or face dizziness	
	☐ slurred speech	☐ headaches	☐ seizure	☐ sleep disturbance
	☐ numbness	☐ loss of consciousness	☐ stress	☐ tremor
	☐ Parkinson's	☐ multiple sclerosis	☐ unsteady gait/loss of balance	
Psychological	☐ None	☐ bi-polar disorder	☐ depression	☐ anxiety
	☐ ADD	☐ ADHD	☐ hallucinations	☐ memory loss
	☐ confusion	☐ insomnia	☐ behavioral change	☐ mood
Hematologic	☐ None	☐ easy bleeding	☐ blood transfusion	☐ fatigue
	☐ anemia	☐ blood clotting	☐ easy bruising	☐ swollen lymph nodes
	☐ recurring infection			