Apex at Jackson Chiropractic New Patient Intake Form

Appointment _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ MI _____ Last Name _____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

How did you hear about our office? ☐ Family/Friend ☐ Facebook ☐ Workshop ☐ Internet
☐ Newspaper ☐ Screening _____ ☐ Other: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Email _____

Social Security Number: _____-_____-_____ Marital Status: ☐ Single ☐ Married ☐ Other

Home Address _____

City _____ State _____ Zip Code _____

Primary Care Physician _____ Phone _____

Emergency Contact _____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____) _____

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Employer Name: _____

Your Occupation _____

Spouse First Name _____ MI _____ Last Name _____

Home Phone (_____) _____ Work Phone _____

Spouse Date of Birth _____/_____/_____

Are You Pregnant? ☐ Yes ☐ No Date of last menstrual period _____

Medical Conditions: (Check all that apply)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis	☐ Other _____

Surgeries: (Check all that apply)

☐ Cervical spine ☐ Thoracic spine ☐ Lumbar spine ☐ Other _____

Allergies: (Check all that apply)

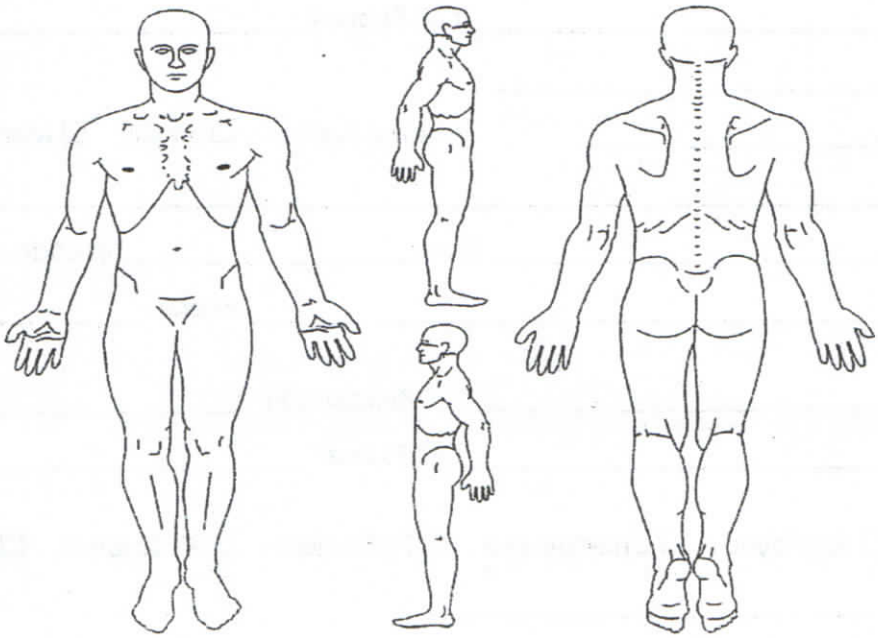
☐ Animal	☐ Chemical _____		☐ Milk/Lactose	☐ Mold
☐ Seasonal	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____	

Social History: (Check all that apply)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Drink Water	☐ Less than 64 oz/day	☐ More than 64 oz/day	☐ never
Cigarettes:	☐ Less than 1 pack/day	☐ More than 1 pack/day	☐ never
Sleep:	☐ Less than 8 hours/night	☐ More than 8 hours/night	☐ insomnia

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Past week: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Does anything improve your pain? ☐ No ☐ Yes _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work-related Accident ☐ Other _____

When did your symptoms begin? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting ☐ Burning

☐ Tingling ☐ Throbbing ☐ Other _____

Review of Systems: (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing				Eyes	Past	Present	No
Pace Maker								Glaucoma			
Jaw Pain								Double Vision			
Irregular Heartbeat								Blurred Vision			
Swelling of legs											
Genitourinary	Past	Present	No	Hematologic	Past	Present	No	Ear, Nose and Throat	Past	Present	No
Kidney Disease				Hepatitis				Difficulty Swallowing			
Burning Urination				Blood Clots				Dizziness			
Frequent Urination				Cancer				Hearing Loss			
Blood in Urine				Bruising				Sore Throat			
Kidney Stones				Bleeding				Nosebleeds			
Lower Side Pain				Fever, Chills				Bleeding Gums			
				Sweating				Sinus Infections			
				Varicose Vein							
Neurologic	Past	Present	No	Musculoskeletal	Past	Present	No	Gastrointestinal	Past	Present	No
Stroke				Gout				Gall Bladder Problems			
Seizures				Arthritis				Bowel Problems			
Head Injury				Joint Stiffness				Constipation			
Brain Aneurysm				Muscle Weakness				Liver Problems			
Numbness				Osteoporosis				Ulcers			
Severe Headaches				Broken Bones				Diarrhea			
Pinched Nerves				Joints Replaced				Nausea/Vomiting			
Parkinson's				Neck Pain				Bloody Stools			
Carpal Tunnel				Low Back Pain				Poor Appetite			
Vertigo				Upper Back Pain							
Constitutional	Past	Present	No	Endocrine	Past	Present	No	Psychiatric	Past	Present	No
Weight Loss/Gain				Thyroid				Depression			
Low Energy Level				Diabetes				Anxiety			
Difficulty Sleeping				Hair Loss				Stress			
				Menopausal							
				PMS							

Please list all current medications being taken _____

_____

_____