PRECISION
CHIROPRACTIC

Intake Form

PATIENT INFORMATION

First Name _____ MI ____ Last Name _____

Home Address _____ City/State/Zip _____

Home Phone _____ Mobile Phone _____

Email Address _____

Date of Birth _____ Shoe Size W M _____

Marital Status _____ # of Children _____ Height _____ Weight _____ Sex: M F

Emergency Contact Name and Phone Number _____

EMPLOYMENT INFORMATION

Full Time ____ Part Time ____ Student ____ Retired ____ Unemployed ____ Other ____

Employer Name _____ Occupation _____

Physical Work Duties _____
_____
_____

Have you ever been to a chiropractor? Yes No
If so, who? _____

Purpose of your visit:

Wellness ____ Pain ____ Injury ____ Neurological Care ____ Performance Training ____

CURRENT COMPLAINTS

Due to a car accident? Yes ___ No ___ If yes, please ask for additional intake paperwork.
Due to an accident at work? Yes ___ No ___ If yes, please notify front desk staff.

Complaint #1 _____

Please describe the **location**, **intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

Complaint #2 _____

Please describe the **location**, **intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

Complaint #3 _____

Please describe the **location, intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

Complaint #4 _____

Please describe the **location, intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

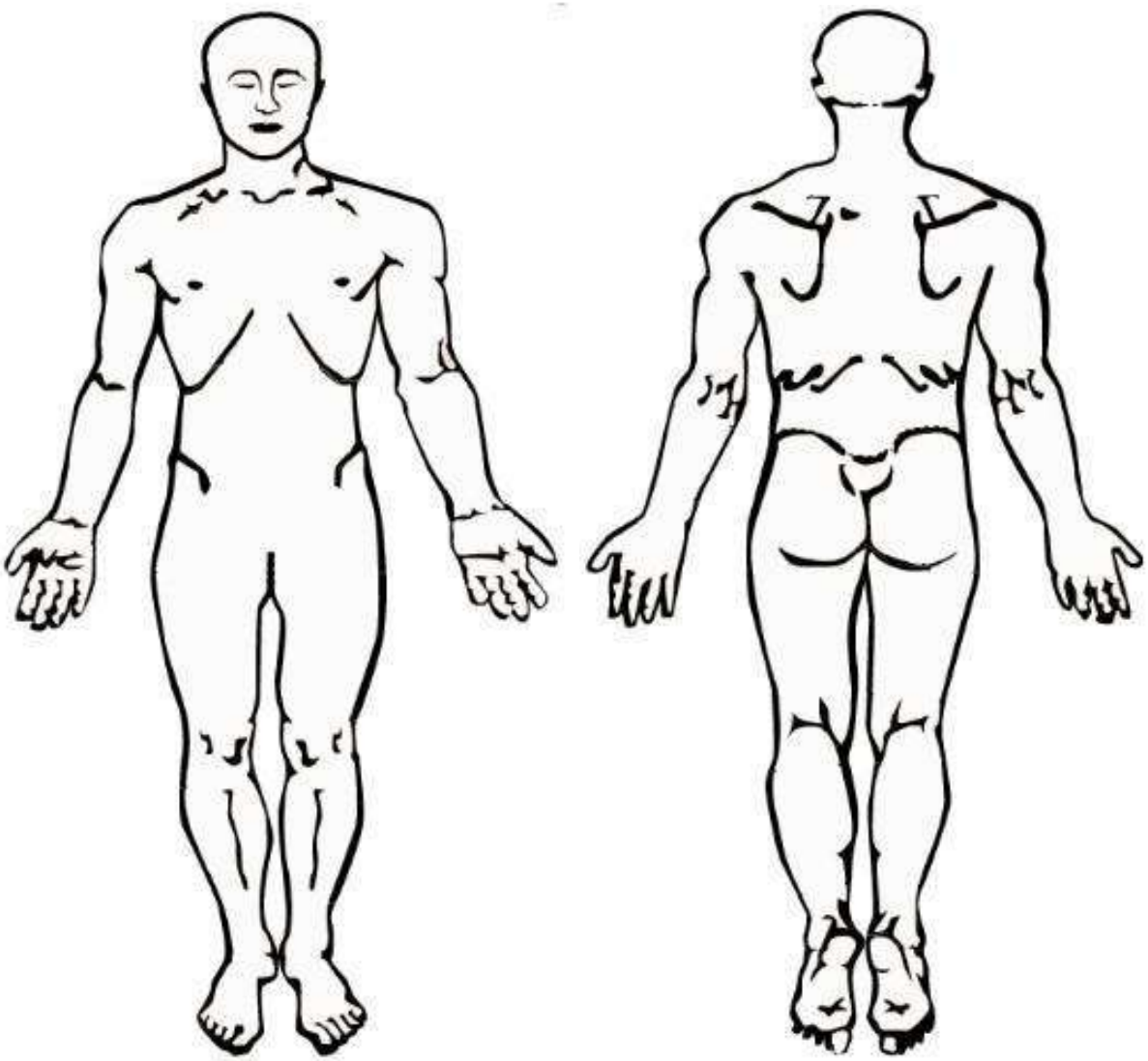
When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

*** If you have additional complaints, please ask the front desk staff to provide you with additional forms.

Please place <u>letters</u> at areas of pain or discomfort on the diagrams below.

Now, please rate each of on a scale of 1-10, with 10 being the worst:

A____ B____ C____ D____ E____ F____ G____ H____ I____ J____ K____ L____ M____



Are you a smoker? Yes ___ No ___ If yes, how many packs per day? _____

How much exercise (greater than 30 minutes) do you get per week? _____ times per week

What type of exercise? _____

PERSONAL HEALTH HISTORY

Date of Last Physical Exam _____ Name of Physician _____

Physician Phone _____ Physician City/State _____

Please list conditions you have been treated for in the last 10 years:

Please list all surgeries and operations:

Please list all current medications/dosages:

Please list all nutritional supplementation (please also include vitamins, minerals, and herbs):

What else should we know to provide the best health care to you?

Which **ONE** of the following do you **MOST** take into consideration when making decisions about your healthcare and the providers you choose?

_____ Cost _____ Time _____ Results _____ Integrity

By signing below I authorize Precision Chiropractic ATX and its staff to use the information provided herein to help make the best decisions for my care. I certify that the information provided is true and accurate to the best of my knowledge. I understand that Precision Chiropractic ATX will work with my insurance company to obtain the highest reimbursement for care, but all costs associated with care are ultimately the responsibility of the patient. All payments are due at the time of service unless otherwise agreed upon in writing by both Precision Chiropractic ATX and the patient.

_____ _____

Patient/Guardian Signature Date

How did you find Precision Chiropractic?

___ Referral from current patient Who? _____

___ Referral from healthcare provider Who? _____

___ Fitness professional Who? _____

___ Print advertising Where? _____

___ Google

___ Facebook

___ Yelp

___ Sign/Building

___ Doctor/Staff Presentation

___ Other _____

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head	_____	Headaches
	_____	Faintness
	_____	Dizziness
	_____	Insomnia
		Total _____
Eyes	_____	Watery or Itchy Eyes
	_____	Swollen, Reddened or Sticky Eyelids
	_____	Bags or Dark Circles Under Eyes
	_____	Blurred or Tunnel Vision (does not include near or far-sighted)
		Total _____
Ears	_____	Itchy Ears
	_____	Earaches, Ear Infections
	_____	Drainage from Ear
	_____	Ringing in Ears, Hearing Loss
		Total _____
Nose	_____	Stuffy Nose
	_____	Sinus Problems
	_____	Hay Fever
	_____	Sneezing Attacks
	_____	Excessive Mucus Formation
		Total _____
Mouth/ Throat	_____	Chronic Coughing
	_____	Gagging, Frequent Need to Clear Throat
	_____	Sore Throat, Hoarseness, Loss of Voice
	_____	Swollen or Discolored Tongue, Gums, or Lips
	_____	Canker Sores
		Total _____
Skin	_____	Acne
	_____	Hives, Rashes, Dry Skin
	_____	Hair Loss
	_____	Flushing, Hot Flashes
	_____	Excessive Sweating
		Total _____
Heart	_____	Irregular or Skipped Heartbeat
	_____	Rapid or Pounding Heartbeat
	_____	Chest Pain
		Total _____

Lungs	_____	Chest Congestion
	_____	Asthma, Bronchitis
	_____	Shortness of Breath
	_____	Difficulty Breathing

Total _____

Digestion	_____	Nausea, Vomiting
	_____	Diarrhea
	_____	Constipation
	_____	Bloated Feeling
	_____	Belching, Passing Gas
	_____	Heartburn
	_____	Intestinal/Stomach Pain

Total _____

Joints/	_____	Pain or Aches in Joints
Muscles	_____	Arthritis
	_____	Stiffness or Limitation of Movement
	_____	Pain or Aches in Muscles
	_____	Feeling of Weakness or Tiredness

Total _____

Weight	_____	Binge Eating/Drinking
	_____	Craving Certain Foods
	_____	Excessive Weight
	_____	Compulsive Eating
	_____	Water Retention
	_____	Underweight

Total _____

Energy/	_____	Fatigue, Sluggishness
Activity	_____	Apathy, Lethargy
	_____	Hyperactivity
	_____	Restlessness

Total _____

Mind	_____	Poor Memory
	_____	Confusion, Poor Comprehension
	_____	Poor Concentration
	_____	Poor Physical Condition
	_____	Difficulty in Making Decisions
	_____	Stuttering or Stammering
	_____	Slurred Speech
	_____	Learning Disabilities

Total _____

Emotions	_____	Mood Swings
	_____	Anxiety, Fear, Nervousness
	_____	Anger, Irritability, Aggressiveness
	_____	Depression

Total _____

Other	_____	Frequent Illness
	_____	Frequent or Urgent Urination
	_____	Genital Itch or Discharge

Total _____

Grand Total _____

PRENATAL HISTORY

Is this your first pregnancy? *Yes/No* ~ How many other births have you had? _____

How many weeks pregnant are you now? _____ Due Date: _____/_____/_____

Have you experienced any traumas (accidents, falls) during this/past pregnancy? *Yes/No*

Please describe: _____

Any medications taken during this pregnancy? _____

Do you smoke or drink alcohol? _____

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? *Yes/No* ~ Please list dates, frequency and reason for these procedures:
_____

How has your diet been during this pregnancy?
_____

Do you take supplements? *Yes/No* ~ If yes, what are you taking?
_____

How much water are you drinking per day? _____

Have there been any stressful events in your life during this pregnancy?
_____

What are your most significant fears associated with this birth?
_____

Who is your birth care provider? _____

Where do you plan on delivering? _____

Will you have someone with you at birth for support (other than a birth care provider)? *Yes/No*

Please specify who: _____

Have you put together a birth plan? *Yes/No*

PREVIOUS BIRTH HISTORY

Please complete this page for each previous delivery

Baby's Name: _____ Date of Birth:_____/_____/_____

Weight: _____ Length: _____ APGAR score: _____

Place of Birth: *Hospital/Birthing Center/Home*

Delivering Practitioner:

OB-Gyn/Certified Nurse Midwife/Certified Practicing Midwife/Lay Midwife

Position of Delivery:

Lihotomy Position (on back, feet up)/On your side/Kneeling/Squatting

Type of Birth: *C-Section/Vaginal*

*Other:*_____

Was labor induced? *Yes/No* ~ If yes, please specify: *Pitocin / Prostaglandin Gel / Unknown*

Were your membranes ruptured by your care provider? *Yes/No*

Were contractions stimulated intravenously with Pitocin once labor started? *Yes/No*

Did you receive any pain medication or anesthesia? *Yes/No* ~ Epidural? *Yes/No*

How many cm were you dilated when it was administered? _____*cm*

Did you experience back pain during labor? *Yes/No*

Baby presentation at time of delivery: _____

If breech specify: *Footling / Frank / Complete / Kneeling* _____

Did your care provider assist delivery with his/her hands? *Yes/No*

Was there any turning of the neck or traction / pulling applied to the neck? *Yes/No*

Were operative devices used to facilitate the birth? *Yes/No*

If yes, which type?: *Forceps / Vacuum Extraction* _____

Were there any visible signs of injury to your baby? *Yes/No*

If yes, where?: _____

Was there a birthing coach present? *Yes/No*

At what week of pregnancy was your baby born? _____

Other information that may be specific to the birth: _____