West Family Chiropractic

Confidential New Patient Intake Form

(Please Print)

'Today' Date_____/_____/_____ (Office use only) Chart Number_____

Patient Information

Mr./ Mrs./ Ms. Miss. / Dr./.....	Name	Nick Name

Mailing Address	City	State	Zip

Birth Date	Age	Marital status	Home phone	Cell phone	Work phone
		S / M / D / W			

Social Security (optional)			Preferred method of contact **(Check one)**
			☐Home phone ☐Cell phone ☐Email

Email address		Race and Preferred Language

Employer	Employer Address

Occupation

Typical Job Duties/Description

Primary Care Physician (PCP)	PCP Address	PCP Phone
		( )

Who referred you to our office?

Family Spouse Information

Spouses Name

Number of Children

Insurance Information

Are You Insured ? ☐Yes ☐ No **[If primary insurance holder is not you, please fill out section below]**

Name of primary subscriber	Subscribers Birth Date	
	/ / /	

Personal, Automobile or Work Related Injury Information

*** If this a **Personal**, **Automobile** or **Work Related** injury please fill out additional forms at the front desk

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Name:_____ Date_____ (Office use only) Chart Number_____

Health history

Complaint / Symptom #1

Complaint / Symptom #2

Complaint/Symptom #3

Complaint/Symptom #4

On a scale of 0-10 with 10 being the worst, please circle the number that best describes your complaints most of the time?

Complaint / Symptom #1: 0 1 2 3 4 5 6 7 8 9 10

Complaint / Symptom #2: 0 1 2 3 4 5 6 7 8 9 10

Complaint / Symptom #3: 0 1 2 3 4 5 6 7 8 9 10

Complaint / Symptom #4: 0 1 2 3 4 5 6 7 8 9 10

What percentage, **(0-100%)**, of the time you are awake do you experience the complaint/symptom at the above intensity?

Complaint/ symptom #1: _____ %

Complaint/ symptom #2: _____%

Complaint/ symptom #3: _____ %

Complaint/ symptom #4: _____ %

How long have you had each complaint?

Did these complaints begin suddenly or gradually?

What do you think caused your current problem(s)?

What makes the Complaints/ Symptoms worse?

What makes the Complaints/ Symptoms better?

Have you ever had these complaints before? ☐Yes ☐ No (If yes please list)

Have you seen other practitioners for these complaints? ☐Yes ☐ No (If yes please list)

Have you had chiropractic care before? ☐Yes ☐ No (If yes please list)

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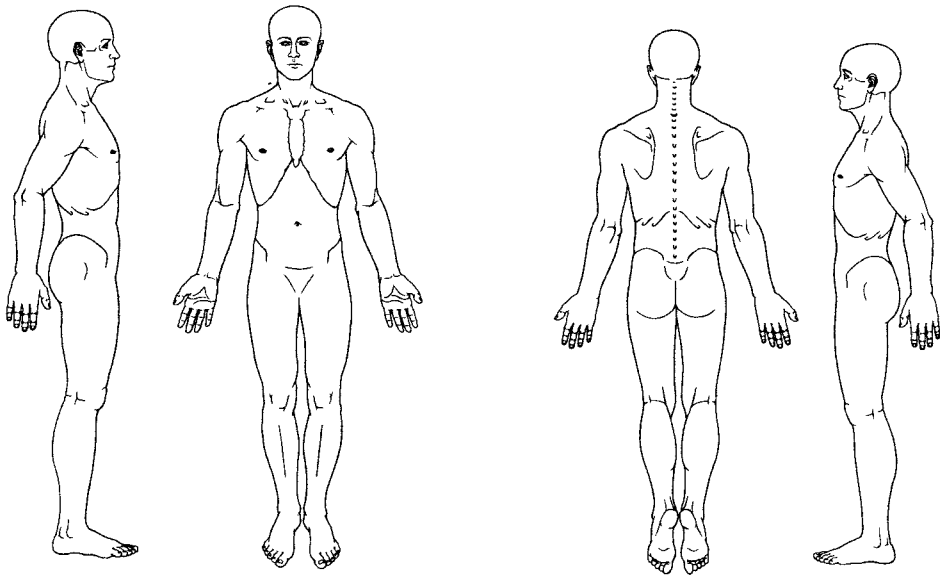
Pain & Symptom Drawing

Please mark the areas on the picture below that correspond to the areas of the body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
Do not simply circle the area of involvement please

Numbness ----- Pins & needles oooooo Burning xxxxx Aching □□□□ Stabbing /////



Past Medical Health history	
Please list any other current health conditions	
Please list any history of surgeries	
Please list any fractures or dislocations	

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Please list current medications	
Any allergies to medications?	
Please list current vitamins and supplements	
Any Significant Family health history of heart disease cancer, stroke...?	
Please list any other physicians / Practitioners that you currently see	
Have you been diagnosed with High Blood Pressure? If yes, please describe	
Have you been diagnosed with Diabetes? If yes, are you type 1 or 2? Any other comments about your diabetes?	
Do you currently smoke tobacco of any kind? Y / N If yes, everyday or sometimes? **Are you interested in quitting? Y / N** **If NO, have you had a past history of smoking? Y / N**	

I certify that the above information is correct to the best of my knowledge.

Signature: _____ Date_____/_____/_____