PARK RIDGE CHIROPRACTIC

Patient Intake Form

First Name:_____ Last Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Email:_____

Birthdate: _____ Sex: _____Male _____Female

Cell Phone: _____ Home Phone: _____

Marital Status: ____Single ____Married ____Widowed ___Other_____

Spouse First Name: _____ Last Name:_____

Cell Phone: _____ Work Phone: _____

Employment Status ____ Full Time ____Part Time ____Unemployed ____Other_____

Name: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name:_____ Relationship: _____

Contact Phone: _____

Who can we thank for referring you? _____

Payment:_____ Major Medical Insurance Insurance Carrier:_____

____Worker's Compensation ____Motor Vehicle Accident ___Cash

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Reason for Visit: _____

How did this happen? _____

Is there Numbness or Tingling? _____ If yes, where? _____

Is there shooting pain? _____ If yes, where? _____

When did this start? _____

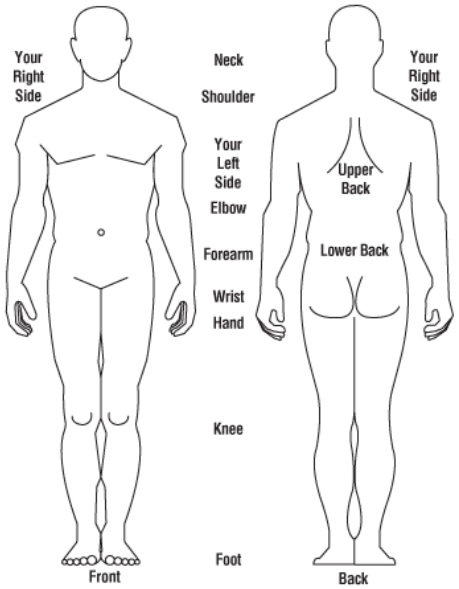
Pain level today? (0=no pain, 10=Intense pain) _____

What type of pain is this? (Check all that apply) ___Achy ___Burning ___Dull ____Throbbing ___Numbness ___Shooting ___Sharp ___ Tingling ___Cramps ___Stiffness ___Swelling ___Other_____

How often during the day do you experience your symptoms?

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

Please Place an **X** where symptoms are present:



PARK RIDGE CHIROPRACTIC

Medical Conditions:

	Arthritis		Heart Disease		Skin Disorders
	Cancer		Hypertension		Stroke
	Diabetes		Psychiatric Illness		Other

Explanation: _____

Surgeries:

	Appendectomy		Cardiovascular		Cervical Spine
	Hysterectomy		Joint Replacement		Prostate
	Lumbar Spine		Gall Bladder		Brain
	Thoracic Spine		Shoulder		Knee
	Carpal Tunnel		Gastro-intestional		Hernia
	Other				

Explanation: _____

Social History:

Caffeine Use:		Occasional		Often		Never
Alcohol Use:		Occasional		Often		Never
Exercise:		Occasional		Often		Never
Chew Tobacco:		Occasional		Often		Never
Cigarettes:		<1 pack/day		>1 pack/day		Never

Explanation: _____

Family History:

Arthritis		Parent		Sibling
Cancer		Parent		Sibling
Diabetes		Parent		Sibling
Heart Disease		Parent		Sibling
Hypertension		Parent		Sibling
Stroke		Parent		Sibling
Thyroid		Parent		Sibling
Other				

Explanation: _____