For Office Use Only

Account Number: _____

Date: _____

Ascension Wellness Center

CHIROPRACTIC & ACUPUNCTURE

Patient Intake Form

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone (Home): _____ Phone (Mobile): _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital Status: S M D W

Email Address: _____

Occupation: _____ Employer: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Have you ever received chiropractic care? Y N If yes, when? _____

Primary Complaint

2. Primary reason for seeking chiropractic care: _____

   Additional reasons for seeking chiropractic care: _____

   _____

3. Have you had this condition before? Y N If yes, when? _____

   What treatments did you seek for this condition? _____

   Were the treatments helpful? _____

4. Is your present condition due to an injury? Y N

   Work related? Y N Auto accident? Y N Other? Y N

   Has the accident been reported to an employer or an insurance provider? Y N

   Has your case been referred to an attorney? Y N

5. When did your complaint begin? _____

6. What caused your complaint to begin? _____

7. How does your complaint affect your activities of daily living? _____

8. Please describe the Location of your complaint: _____

9. Please circle the Quality of the complaint/pain: Dull Aching Tight Sharp Shooting Burning Nagging Other_____

10. Does your complaint/pain Radiate or Travel to other areas of your body? Y N

    If yes, where? _____

11. Do you experience any numbness or tingling in your body? Y N

    If yes, where? _____

12. Please circle the number that most accurately grades the Intensity/Severity of your complaint/pain

    (No discomfort or pain) 0 1 2 3 4 5 6 7 8 9 10 (The worst pain imaginable)

13. How frequently is your complaint/pain present?

    Rarely (0-25%) Occasionally (26-50%) Often (51-75%) Constantly (76-100%)

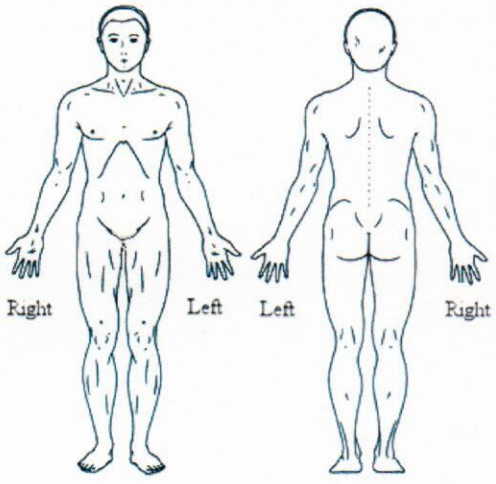
14. How long does your complaint/pain last? _____

15. Does anything aggravate your complaint/pain? _____

16. Does anything make your complaint/pain better? _____

17. Is there any time of day when your complaint/pain is worse? Y N If yes, when?_____

18. Is your complaint/pain getting better, worse or staying the same? _____



Using the symbols below, mark on the pictures where you feel pain.

Numbness	N
Dull Ache	A
Burning	B
Sharp/Stabbing	S
Pins, Needles	P
Other _____	O

19. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

20. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

21. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

22. Do you have any infectious diseases? Y N If yes, please identify: _____

23. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox

24. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: _____

25. **Family History:** Check those applicable:	Father	Mother	Siblings	Children	Grandparents
Age (if living)					
Health (G=Good, P=Poor)					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Mental Illness					
Asthma/Hay Fever/Hives					
Kidney Disease					
Age (at death)					
Cause of Death					

26. **Height:** _____ **Weight:** _____

27. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this taken? _____

28. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

29. **X-Rays/CAT Scans/MRI's/Special Studies:**

Reason	When	Reason	When

30. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Anxiety Depression

31. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

32. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

33. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

34. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

35. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids

Abdominal Pain

36. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

37. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps Breast Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

38. **Birthing History:**

1. # of Pregnancies: _____ 2. # of Healthy Children: _____ 3. # of Miscarriages: _____

39. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Known Issues with Sperm Count/Motility

40. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

41. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

42. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Type I or II

Night Sweats Feeling Hot or Cold

43. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

43. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Level of education completed: High School Bachelors Masters Doctorate Other

e. Occupation: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not? _____

f. Nicotine/Alcohol Use: _____

g. Recreational Drug Use: _____

h. Have you experienced any major traumas? Y N If yes, explain: _____

_____

i. How many glasses of caffeinated/energy beverages do you consume per day? _____

j. How many glasses of actual water do you drink per day? _____

k. Television habits: _____ Reading habits: _____

l. Interests and hobbies: _____

How did you hear about Ascension Wellness Center? _____