Stroteide
CHIROPRACTIC & PHYSICAL THERAPY
Where Pain Ends & Wellness Begins

New Patient Intake Form

Please Complete In Entirety

Patient Name: _____ Date:_____

Confidential Patient Health Record

***Today's Date*:___/____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Close to home/work** ☐ **Dr.** _____ ☐ **Yellow pages** ☐ **Drove by** ☐ **Hospital** ☐ **Insurance Plan**

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Birth Date: ____/____/_____ **Age:**_____ **Sex: Male / Female**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____**)** _____-_____ **ext** _____ **Work Phone: (**_____**)** _____-_____ **ext** _____

Cell Phone: (_____**)** _____-_____ **ext** _____ **Fax #: (**_____**)** _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ **First:**_____**Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____**)** _____-_____ **ext** _____ **Cell Phone: (**_____**)** _____-_____ **ext** ___

Work Phone: (_____**)** _____-_____ **ext** _____

Employment Information

Business Name: _____

Phone: (_____**)** _____-_____ **Fax #: (**_____**)** _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Patient Name: _____ Date:_____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

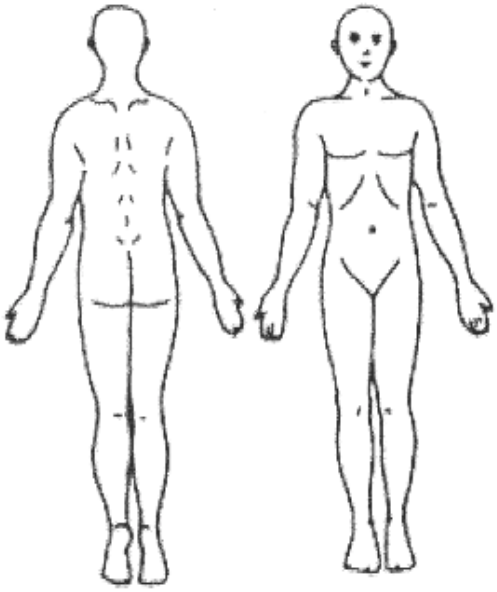
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** _____

Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ **chills**	☐ **fatigue**	☐ **night sweats**	☐ **weight loss**
☐ **daytime drowsiness**	☐ **fever**	☐ **weight gain**	

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **blindness**	☐ **change in vision**	☐ **field cuts**	☐ **photophobia**
☐ **blurred vision**	☐ **double vision**	☐ **glaucoma**	☐ **tearing**
☐ **cataracts**	☐ **eye pain**	☐ **itching**	☐ **wear glasses/contacts**

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **bleeding**	☐ **ear drainage**	☐ **hearing loss**	☐ **nosebleeds**	☐ **sore throat**
☐ **dentures**	☐ **ear pain**	☐ **history of head injury**	☐ **postnasal drip**	☐ **tinnitus (ringing in ears)**
☐ **difficulty swallowing**	☐ **fainting**	☐ **hoarseness**	☐ **rhinorrhea (runny nose)**	☐ **TMJ problems**
☐ **discharge**	☐ **frequent sore throats**	☐ **loss of sense of smell**	☐ **sinus infections**	
☐ **dizziness**	☐ **headaches**	☐ **nasal congestion**	☐ **snoring**	

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **asthma**	☐ **coughing up blood**	☐ **sputum production**

Patient Name: _____ Date:_____

☐ **cough** ☐ **shortness of breath** ☐ **wheezing**

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **angina (chest pain or discomfort)**	☐ **high blood pressure**	☐ **shortness of breath with exertion or exercise**
☐ **chest pain**	☐ **low blood pressure**	☐ **swelling of legs**
☐ **claudication (leg pain/ache)**	☐ **orthopnea (difficulty breathing lying down)**	☐ **ulcers**
☐ **heart murmur**	☐ **palpitations**	☐ **varicose veins**
☐ **heart problems**	☐ **paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)**	

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **abdominal pain**	☐ **diarrhea**	☐ **indigestion**	☐ **abnormal stool caliber**	☐ **vomiting blood**
☐ **belching**	☐ **difficulty swallowing**	☐ **jaundice**	☐ **abnormal stool color**	
☐ **black - tarry stools**	☐ **heartburn**	☐ **nausea**	☐ **abnormal stool consistency**	
☐ **constipation**	☐ **hemorrhoids**	☐ **rectal bleeding**	☐ **vomiting**	

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ **birth control**	☐ **cramps**	☐ **irregular menstruation**	☐ **vaginal bleeding**
☐ **breast lumps/pain**	☐ **frequent urination**	☐ **pregnancy**	☐ **vaginal discharge**
☐ **burning urination**	☐ **hormone therapy**	☐ **urine retention**	

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **burning urination**	☐ **frequent urination**	☐ **prostate problems**
☐ **erectile dysfunction**	☐ **hesitancy/ dribbling**	☐ **urine retention**

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **cold intolerance**	☐ **excessive hunger**	☐ **goiter**	☐ **unusual hair growth**
☐ **diabetes**	☐ **excessive thirst**	☐ **hair loss**	☐ **voice changes**
☐ **excessive appetite**	☐ **abnormal frequency of urination**	☐ **heat intolerance**	

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **changes in nail texture**	☐ **hair loss**	☐ **itching**	☐ **skin lesions / ulcers**
☐ **changes in skin color**	☐ **hives**	☐ **paresthesias**	☐ **varicosities**
☐ **hair growth**	☐ **history of skin disorders**	☐ **rash**	

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **dizziness**	☐ **limb weakness**	☐ **numbness**	☐ **slurred speech**	☐ **tremor**
☐ **facial weakness**	☐ **loss of consciousness**	☐ **seizures**	☐ **stress**	☐ **unsteadiness of gait/ loss of balance**
☐ **headache**	☐ **loss of memory**	☐ **sleep disturbance**	☐ **strokes**	

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **anhedonia**	☐ **behavioral change**	☐ **convulsions**	☐ **memory loss**
☐ **anxiety**	☐ **bi-polar disorder**	☐ **depression**	☐ **mood change**
☐ **loss or change in appetite**	☐ **confusion**	☐ **insomnia**	

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **anaphylaxis**	☐ **itching**	☐ **chronic nasal congestion**	☐ **sneezing**
☐ **food intolerance**	☐ **acute nasal congestion**	☐ **rash**	

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **anemia**	☐ **blood clotting**	☐ **bruising easily**	☐ **lymph node swelling**
☐ **bleeding**	☐ **blood transfusion**	☐ **fatigue**	

Patient Name: _____ Date:_____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
□ I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____
Type of Treatment: _____ Was the treatment beneficial in resolving condition? □ Yes □ No

Explain: _____

Previous Chiropractic Care: **□ I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

□ ADD
□ atopic dermatitis (eczema)
□ allergies/hay fever
□ anemia
□ asthma
□ bedwetting
□ cerebral palsy
□ chicken pox
□ crohn's/colitis
□ depression
□ diabetes
□ ear infections
□ fetal drug exposure
□ food allergies (list below)
□ headaches
□ hepatitis
□ HIV
□ measles
□ mumps
□ psoriasis
□ rash
□ scoliosis
□ seizure disorder
□ sickle cell anemia
□ spina bifida
□ other:

Adult Illness(es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

□ ADD
□ Alzheimer's
□ anemia
□ arthritis
□ asthma
□ cancer
□ cerebral palsy
□ chicken pox
□ crohn's/colitis
□ CRPS (RSD)
□ CVA (stroke)
□ cystic kidney disease
□ depression
□ diabetes (insulin dep)
□ diabetes (non insulin)
□ eczema
□ emphysema
□ eye problems
□ fibromyalgia
□ heart disease
□ hepatitis
□ HIV
□ hypertension
□ influenza pneumonia
□ liver disease
□ lung disease
□ lupus erythema (discoid)
□ lupus erythema (systemic)
□ multiple sclerosis
□ Parkinson's disease
□ unspecified pleural effusion
□ pneumonia
□ psoriasis
□ psychiatric problems
□ scoliosis
□ seizures
□ shingles
□ past history of similar symptoms
□ STD's (unspecified)
□ suicide attempt(s)
□ thyroid problems
□ vertigo
□ other:

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? □ yes or □ no.

Patient Name: _____ Date:_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsillectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Insurance Information:

Who Is Responsible For Your Bill? **YOU and… (mark appropriate box(es))** ☐ **Myself ONLY**

☐ **Spouse** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Medicaid** ☐ **Other (be specific):_____**

Personal Health Insurance Carrier: _____ **Health ID Card #:** _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Date of Birth: _____-_____-_____ **Primary Care Physician:** _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐**Yes** ☐ **No** **Date:____/____/_____Time: _____am/pm**

Carrier: _____ **Policy #** _____

Carriers Phone #: (_____) _____-_____ **Adjuster:** _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ **Date:** _____
Patient's Signature: _____ **Date:** _____