NOMAD CHIROPRACTIC
KEEPING YOU MOVING

INTAKE FORM

PERSONAL INFORMATION

DATE: _____

FIRST NAME:_____ M.I._____LAST NAME:_____

PREFERRED NAME:_____ SOCIAL SECURITY NUMBER:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

MOBILE #:_____ HOME #: _____ WORK #:_____

EMAIL: _____(FOR UPDATES ON OFFICE HOURS, EVENTS, ETC)

DATE OF BIRTH:_____ AGE:_____ GENDER:_____

OCCUPATION: _____ EMPLOYER:_____

MARITAL STATUS: S M D W SPOUSE NAME: _____

CHILDREN'S NAME AND AGES: _____

HAVE YOU RECEIVED CHIROPRACTIC CARE BEFORE: (YES / NO) WHEN:_____ WHERE:_____

REFERRED BY: (NAME) _____ (FAMILY/FRIEND/CO-WORKER/INTERNET/OTHER)

EMERGENCY CONTACT INFORMATION

NAME: (FIRST, MI, LAST) _____

PHONE #:_____ RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #:_____

FINANCIAL INFORMATION/ RESPONSIBLE PARTY

☐ TIME OF SERVICE ☐ PERSONAL INJURY/AUTO ☐ OTHER_____

☐ MEDICARE ☐ WORKER'S COMP

NAME OF PRIMARY RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / CHILD DATE OF BIRTH:_____

I HAVE MEDICARE: _____ THE REASON FOR THIS VISIT IS FROM A RECENT AUTO ACCIDENT_____

REASON FOR SEEKING CARE – PRIMARY

PRIMARY COMPLAINT: _____

WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM:_____

HOW DID THIS PROBLEM FIRST BEGIN? _____

DOES ANYTHING MAKE THE COMPLAINT BETTER?

__ICE __HEAT __REST __ MOVEMENT __STRETCHING __CHIROPRACTIC __ OTHER:_____

DOES ANTHING MAKE THE COMPLAINT WORSE?

__SIT __STAND __WALK __LYING __ SLEEPING __ OVERUSE __OTHER:_____

WHAT HAVE YOU TIRED TO RELIEVE THIS PROBLEM? (INTERVENTIONS, TREATMENTS, MEDICATIONS, SURGERY, ETC)_____

HOW WOULD YOU DESCRIBE THE SYMPTOMS OF THIS PROBLEM?

☐ BURNING ☐ ACHING ☐ TINGLING ☐ DULL ☐ OTHER_____

☐ STABBING ☐ SHARP ☐ NUMB ☐ STIFF & SORE

PLEASE DESCRIBE THE LOCATION OF THE PAIN OR SYMPTOM: _____

DOES THIS COMPLAINT RADIATE/SHOOT TO ANY OTHER AREAS OF YOUR BODY? (YES / NO)

WHERE?_____

PLEASE RATE THE SEVERITY OF THE PROBLEM:

AT WORST: LOW 1 2 3 4 5 6 7 8 9 10 HIGH

TODAY: LOW 1 2 3 4 5 6 7 8 9 10 HIGH

IS THIS CONDITION WORSE IN THE: _____ MORNING _____ MID-DAY _____EVENING

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM?

☐ LESS THAN 25% (INTERMITTENT) ☐ 26-50% (OCCASIONALLY)

☐ 51-75% (FREQUENT) ☐ 76%+ OF THE TIME (CONSTANT)

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS PROBLEM? (YES / NO)

WHO AND WHAT WERE THEIR RECOMMENDATIONS? _____

REASON FOR SEEKING CARE – SECONDARY

SECONDARY COMPLAINT: _____

WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM:_____

HOW DID THIS PROBLEM FIRST BEGIN? _____

DOES ANYTHING MAKE THE COMPLAINT BETTER?

__ICE __HEAT __REST __ MOVEMENT __STRETCHING __CHIROPRACTIC __ OTHER:_____

DOES ANTHING MAKE THE COMPLAINT WORSE?

__SIT __STAND __WALK __LYING __ SLEEPING __ OVERUSE __OTHER:_____

WHAT HAVE YOU TIRED TO RELIEVE THIS PROBLEM? (INTERVENTIONS, TREATMENTS, MEDICATIONS, SURGERY, ETC)_____

HOW WOULD YOU DESCRIBE THE SYMPTOMS OF THIS PROBLEM?

☐ BURNING ☐ ACHING ☐ TINGLING ☐ DULL ☐ OTHER_____

☐ STABBING ☐ SHARP ☐ NUMB ☐ STIFF & SORE

PLEASE DESCRIBE THE LOCATION OF THE PAIN OR SYMPTOM: _____

DOES THIS COMPLAINT RADIATE/SHOOT TO ANY OTHER AREAS OF YOUR BODY?(YES / NO)WHERE:_____

PLEASE RATE THE SEVERITY OF THE PROBLEM: _____

AT WORST: LOW 1 2 3 4 5 6 7 8 9 10 HIGH

TODAY: LOW 1 2 3 4 5 6 7 8 9 10 HIGH

IS THIS CONDITION WORSE IN THE: _____ MORNING _____ MID-DAY _____EVENING

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM?

☐ LESS THAN 25% (INTERMITTENT) ☐ 26-50% (OCCASIONALLY)

☐ 51-75% (FREQUENT) ☐ 76%+ OF THE TIME (CONSTANT)

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS PROBLEM? (YES / NO)

WHO AND WHAT WERE THEIR RECOMMENDATIONS? _____

REVIEW OF SYSTEMS

PLEASE CHECK AND EXPLAIN ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 12 MONTHS OR CHECK THE SPACE FOR NO COMPLAINTS.

MUSCULO-SKETEAL: CHECK AND EXPLAIN ____ NO COMPLAINTS

___LOW BACK PAIN ___PAIN BETWEEN SHOULDERS ___ NECK PAIN ___ ARM/SHOULDER PAIN
___JOINT PAIN/STIFFNESS ___WALKING PROBLEMS ____ GENERAL STIFFNESS

SYMPTOM	DATE LAST EXPERIENCED	TREATMENT RECEIVED
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENITO-URINARY: CHECK AND EXPLAIN ____ NO COMPLAINTS

___PAINFUL/EXCESSIVE URINATION ___DISCOLORED URINE ___BLADDER TROUBLE

SYMPTOM	DATE LAST EXPERIENCED	TREATMENT RECEIVED
_____	_____	_____
_____	_____	_____

CARDIO-VASCULAR-RESPIRATORY: CHECK AND EXPLAIN ____ NO COMPLAINTS

___CHEST PAIN ___SHORT BREATH ___IRREGULAR HEARTBEAT ___BLOOD PRESSURE PROBLEMS
___HEART PROBLEMS ___VARICOSE VEINS ___ANKLE SWELLING ___STROKE
___LUNG PROBLEMS ___CONGESTION

SYMPTOM	DATE LAST EXPERIENCED	TREATMENT RECEIVED
_____	_____	_____
_____	_____	_____

NERVOUS SYSTEM: CHECK AND EXPLAIN ____ NO COMPLAINTS

___NERVOUS ___NUMBNESS ___HEARING DIFFICULTY ___FORGETFULNESS ___CONFUSION
___DEPRESSION ___FAINTING ___PROLONGED STRESS ___DIZZINESS ___PARALYSIS
___CONVULSIONS ___COLD/TINGLING EXTREMITIES

SYMPTOM	DATE LAST EXPERIENCED	TREATMENT RECEIVED
_____	_____	_____
_____	_____	_____

GASTRO-INTESTINAL: CHECK AND EXPLAIN ____ NO COMPLAINTS

___EXCESSIVE THIRST ___FREQUENT NAUSEA ___VOMITING ___BLOODY STOOLS
___CONSTIPATION ___COLITIS ___GALL BLADDER ___WEIGHT TROUBLES ___POOR DIET
___EXCESSIVE APPETITE ___HEMORRHOIDS ___LIVER PROBLEMS ___ABDOMINAL CRAMP
___DIARRHEA ___HEARTBURN ___GAS/BLOATING AFTER MEALS

SYMPTOM	DATE LAST EXPERIENCED	TREATMENT RECEIVED
_____	_____	_____
_____	_____	_____

PLEASE CHECK AND EXPLAIN ANY OF THE FOLLOWING ILLNESSES YOU HAVE EVER HAD:

___CANCER ___DIABETES ___MENTAL DISORDERS ___PNEUMONIA ___HEART DISEASE
___ARTHRITIS ___SMALL POX ___PLEURISY ___POLIO ___RHEUMATIC FEVER ___TB ___EPILEPSY
___ANEMIA ___MEASLES ___WHOOPING COUGH ___MUMPS ___STDS ___THYROID DISORDER

SYMPTOM	DATE LAST EXPERIENCED	TREATMENT RECEIVED
_____	_____	_____
_____	_____	_____

MEDICATIONS

☐ ANXIETY/DEPRESSION ☐ MIGRAINE/HEADACHE ☐ ANTIBIOTICS
☐ ASTHMA ☐ ACID REFLUX ☐ DIGESTIVE
☐ PAIN NARCOTICS ☐ ADD/ADHD ☐ OTHER

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING AND REASON FOR TAKING THEM?

MEDICATION	AMOUNT/FREQUENCY	REASON

VITAMINS/SUPPLEMENTS

MULTI-VITAMIN FISH OIL/OMEGA 3 OTHER
VITAMIN D PROBIOTICS

WHAT VITAMINS OR SUPPLEMENTS ARE YOU CURRENTLY TAKING?

SUPPLEMENT	AMOUNT/FREQUENCY	REASON

LIFESTYLE AND SOCIAL HISTORY

RECREATIONAL ACTIVITIES _____
HOBBIES OR INTERESTS _____
DO YOU SMOKE CIGARETTES? (YES / NO) IF YES, HOW MUCH?_____
DO YOU SMOKE MARIJUANA? (YES / NO) IF YES, HOW MUCH? _____
DO YOU DRINK ALCOHOL? (YES / NO) IF YES, HOW MUCH?_____
DO YOU DRINK COFFEE? (YES / NO) IF YES, HOW MUCH?_____
DO YOU DRINK TEA? (YES / NO) IF YES, HOW MUCH?_____
DO YOU DRINK SODA? (YES / NO) IF YES, HOW MUCH?_____
DAILY WATER INTAKE IN OUNCES? _____ DAILY SERVINGS OF VEGETABLES? _____
DAILY SERVINGS OF FRUIT? _____ HOW MANY TIMES A WEEK DO YOU EAT OUT? _____
HOW MANY MEALS DO YOU OR SOMEONE IN YOUR FAMILY PREPARE EACH WEEK? _____
HOW OFTEN DO YOU EXERCISE? _____ WHAT KIND OF EXERCISE DO YOU DO? _____
HOW MANY HOURSE OF SLEEP DO YOU GET ON AVERAGE EACH NIGHT? _____
WHAT POSITION DO YOU SLEEP IN? _____

PLEASE RATE YOUR STRESS LEVEL IN THE FOLLOWING AREAS. CIRCLE N/A IF NOT APPLICABLE:

PERSONAL RELATIONSHIPS	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
PROFESSIONAL RELATIONSHIPS	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
FOODS YOU EAT	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
MEDICATION	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
SMOKING	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
DRUG USE	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
DIAGNOSED MEDICAL CONDITIONS	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
EXERCISE	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
LACK OF EXERCISE	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A
YOUR OVERALL HEALTH STATUS	LOW	1	2	3	4	5	6	7	8	9	10	HIGH	N/A

PAST HEALTH HISTORY

YOUR PAST SURGERIES:

DATE:	TYPE:	REASON:
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAJOR INJURIES, TRAUMAS, HOSPITALIZATION

DATE:	DESCRIBE:
_____	_____
_____	_____
_____	_____

ALLERGIES:_____

MAJOR SICKNESSES OR DISEASES WITH DATES: _____

_____

PLEASE INDICATE WHETHER YOU HAVE EVER EXPERIENCED STRESS IN ANY OF THE FOLLOWING AREAS. YOUR ANSWERS WILL HELP DETERMINE WHICH FACTORS HAVE CONTRIBUTED TO YOUR PRESENT HEALTH CONDITIONS/CONCERNS. "X" FOR POSITIVE

CHILDHOOD

___REPEATED/PROLONGED ANTIBIOTIC USE
___CAR ACCIDENT
___INHALER USE
___YOUTH SPORTS TRAUMA/INJURY
___HEAD TRAUMA/ CONCUSSION
___SURGERY
___HOME STRESS
___PHYSICAL ABUSE
___EMOTIONAL ABUSE
___SEXUAL ABUSE

ADULTHOOD

___REPEATED/PROLONGED ANTIBIOTIC USE
___CAR ACCIDENT
___INHALER USE
___YOUTH SPORTS TRAUMA/INJURY
___HEAD TRAUMA/CONCUSSION
___SURGERY
___HOME STRESS
___PHYSICAL ABUSE
___EMOTIONAL ABUSE
___SEXUAL ABUSE

FAMILY HEALTH HISTORY

LIST RELEVANT MAJOR HEALTH PROBLEMS OF FIRST DEGREE RELATIVES OR ___N/A
FAMILY HISTORY OF: (CANCER / DIABETES / HYPERTENSION / HEART DISEASE)

PROBLEM	PARENT (M OR F)	SIBLING (B OR S)	CHILD (M OR F)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WOMEN ONLY

WHEN WAS YOUR LAST PERIOD? __________ DO YOU HAVE REGULAR MENSES? _______ MENOPAUSAL?______
DO YOU TAKE BIRTH CONTROL PILLS OR USE A DEVICE OR MEDICATION THAT ALTERS YOUR PERIOD? ________

DATE OF PREGNANCY	OUTCOME
____________________________	____
____________________________	____
____________________________	____
____________________________	____

ARE YOU PREGNANT? (YES / NO / UNSURE)

HEALTH GOALS

WHAT ARE YOUR PRIMARY HEALTH OBJECTIVES? ____
____
ARE YOU HEALTHIER TODAY THAN YOU WERE 5 YEARS AGO? (YES / NO / UNSURE)
IF SO, WHAT DID YOU DO TO IMPROVE YOUR HEALTH?____
____
IF NOT, WHY DID YOUR HEALTH DECLINE? ____
____
WHAT PLANS DO YOU HAVE TO IMPROVE YOUR HEALTH AND WELL-BEING?_______________________________
____

WHAT OTHER WELLNESS PROFESSIONALS ARE CURRENTLY PART OF YOUR HEALTH CARE TEAM?_____________
____
WHICH BEST DESCRIBES THE REASON FOR CONSULTING OUR OFFICE?
___ I HAVE A SPECIFIC CONCERN AND REQUIRE YOUR HELP WITH THIS CONCERN.
___ I WANT TO ENSURE THAT MY HEALTH CONCERNS DO NOT BECOME AN ONGOING PROBLEMS THAT WILL IMPACT MY FUTURE HEALTH
___ I WANT TO BE HEALTHIER FIVE YEARS FROM NOW THAN I AM TODAY?

PATIENT SIGNATURE: ____ DATE: _________________________

PARENT/GUARDIAN SIGNATURE: ______________________________________ DATE: _________________________

DOCTOR SIGNATURE: ____ DATE: _________________________