## Patient Intake Form

Name:_____Date:_____Acct#_____

Date of Birth:_____ How did you hear about our office?_____

Are your present problems due to an injury? ○Yes ○ No

Enter the Date of Injury:_____

Was this injury? ○Work Related ○ Auto Accident ○ Personal Injury ○ Other_____

Has the accident been reported? ○ Yes ○ No If so, to Whom?○ Employer ○ Auto Carrier ○Other

Briefly describe the accident, injury or illness?

_____

_____

_____

List symptoms you are experiencing: Choose the severity associated with each symptom

1._____○1 Very Mild ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Remarkably Severe

Frequency of Pain? ○ Occasional ○ Intermittent ○ Frequent ○None

Type of Pain? ○ Aching ○ Burning ○ Dull ○ Pulling ○ Sharp ○ Shooting ○ Stabbing ○ Stinging ○ Throbbing ○ None

2._____○1 Very Mild ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Remarkably Severe

Frequency of Pain? ○ Occasional ○ Intermittent ○ Frequent ○None

Type of Pain? ○ Aching ○ Burning ○ Dull ○ Pulling ○ Sharp ○ Shooting ○ Stabbing ○ Stinging ○ Throbbing ○ None

3._____○1 Very Mild ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Remarkably Severe

Frequency of Pain? ○ Occasional ○ Intermittent ○ Frequent ○None

Type of Pain? ○ Aching ○ Burning ○ Dull ○ Pulling ○ Sharp ○ Shooting ○ Stabbing ○ Stinging ○ Throbbing ○ None

List any test, studies, or medications received for these conditions:

○ Tests/Studies:_____
○Medications:_____

Were you admitted to the hospital due to this condition: ○ Yes ○ No
If yes, What hospital:_____ Date Admitted:_____
Please list any past treatments you have had:

_____

_____

_____

Please list any past conditions you have had:

_____

**Family History:**

Diabetes ○ Yes ○ No , If yes, whom?_____

Cancer ○ Yes ○ No, If yes, whom? _____

Back Pain ○Yes ○ No If yes, whom?_____

Other ○Yes ○ No If yes, Whom?_____

**Social History:**

Smoking: ○Current Smoker __ per day ○ Former Smoker ○ Never Smoked

Recreational Drugs: ○Current Smoker __ per day ○ Former Smoker ○ Never Smoked

Drinking: ○ Alcohol (cups/day)___ ○ Soft Drinks (cups/day)___ ○ Coffee (cups/day)___ ○Water (cups/day)___

Exercise: ○ Daily ○ Moderate ○ None

Are you currently taking any medication or vitamins? (Prescription or OTC)? ○ Yes ○ No
If Yes, Please list all medications and vitamins you are taking:

_____

_____

Do you have any allergies? ○ Yes ○ No
If Yes, please list any allergies?

_____

_____

Have you ever had any surgeries? ○ Yes ○ No
If Yes, please list what surgeries you have had?

_____

_____

Have you ever been diagnosed with cancer? ○ Yes ○ No If yes, please explain_____
Do you have an implanted neurostimulator device? ○ Yes ○ No If Yes, where? _____
Do you have a pacemaker? ○Yes ○ No
Please check any of the following that may apply to you:

_____Take medications that increase sensitivity to sunlight
_____Have a seizure disorder that is triggered by light
_____ Have hemorrhagic diathesis
_____Been injected with steroids in the past 2-3 weeks
_____Have a cancerous lesion(s) or history of cancerous lesion(s)
_____Take anticoagulants
_____ Are Pregnant
_____Have HIV positive history
_____ Have a pacemaker
_____ Leukemia

**Our office strives to offer each patient an integrated wellness plan based on your condition(s). Please check off any of the following services you may be interested in addition to chiropractic/physical therapy treatments:**
**○ MLS Laser Therapy ○ Essential Oils ○ Vitamin IV Therapy ☐Stem Cell Therapy ☐ Nutritional/Life Coach**

Fees are payable at the time of examinations, x-rays, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of Chicago Chiropractic Center.

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