# Arctic Chiropractic Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

**Name:** _____ **Date:** _____

**Insurance:** _____ (mm/dd/yr)

**Date of Birth:** _____ ☐ **male** ☐ **female**

**Address:** _____

_____ **Marital status**

| S | M | W | D | SEP |
|---|---|---|---|---|

**How did you hear about us?** _____

**Phone #: home:** _____ **work:** _____

**E-mail address:** _____

**Occupation:** _____ **Employer:** _____

***Check ☑ and indicate the age when you had any of the following:***

**General**
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

**Muscle / Joint**
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

**Skin**
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

**Eye, Ear, Nose & Throat**
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

**Gastrointestinal**
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

**Genitourinary**
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

**Cardiovascular**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

**Respiratory**
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

**Women only**
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

**Check any of the conditions you have or have had:**
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

**Please list any medication you are currently taking and why:**

_____

_____

_____

_____

## Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

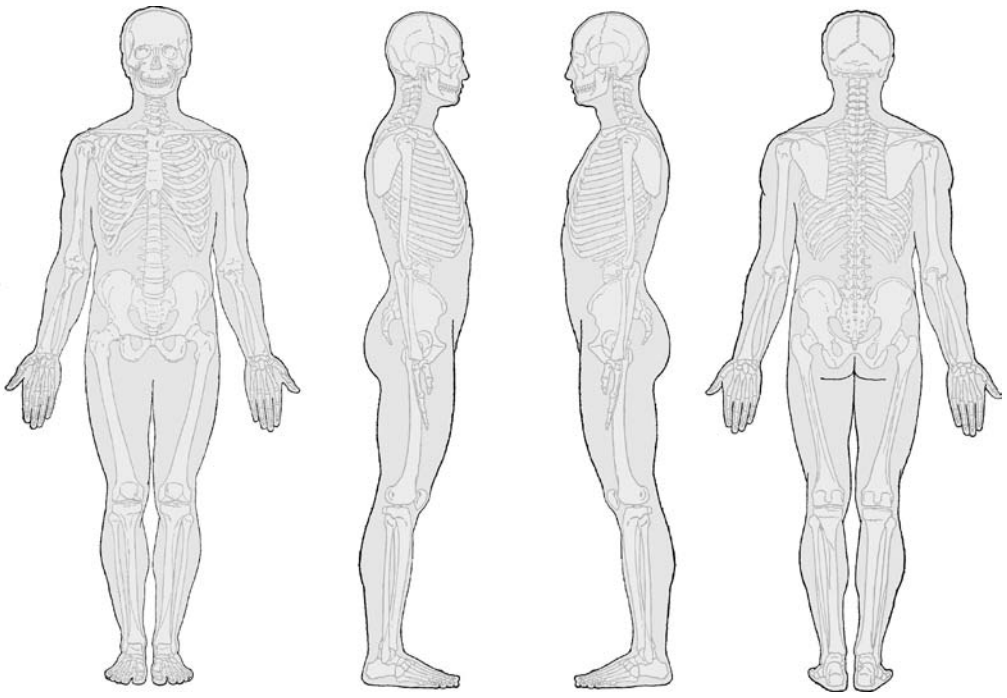
What seemed to be the initial cause: _____

***Please mark you area(s) of pain on the figure below***

***Please place a mark at the level of your pain on the scale below:***

**Worst Possible Pain**

**No Pain**



### Past health history

| Have you... | Yes | No | If yes, explain briefly |
|---|---|---|---|
| ... been hospitalized in the last 5 year? | □ | □ | _____ |
| ... had any mental disorders? | □ | □ | _____ |
| ... had any broken bones? | □ | □ | _____ |
| ... had any strains or sprains? | □ | □ | _____ |
| ... ever used orthotics? | □ | □ | _____ |
| Do you take minerals, herbs or vitamins? | □ | □ | _____ |

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

| Habits | none | light | mod. | heavy |
|---|---|---|---|---|
| Alcohol | □ | □ | □ | □ |
| Coffee | □ | □ | □ | □ |
| Tobacco | □ | □ | □ | □ |
| Drugs | □ | □ | □ | □ |
| Exercise | □ | □ | □ | □ |
| Sleep | □ | □ | □ | □ |
| Soft drinks | □ | □ | □ | □ |
| Salty foods | □ | □ | □ | □ |
| Water | □ | □ | □ | □ |
| Sugar | □ | □ | □ | □ |

### Family history

***If any blood relative has had any of the following conditions, please check and indicate which relative(s)***

| | | |
|---|---|---|
| □ Alcoholism | □ Cancer | □ High blood pressure |
| □ Anemia | □ Diabetes | □ High cholesterol |
| □ Arteriosclerosis | □ Emphysema | □ Multiple sclerosis |
| □ Arthritis | □ Epilepsy | □ Osteoporosis |
| □ Asthma | □ Glaucoma | □ Stroke |
| □ Bleed easily | □ Heart disease | □ Thyroid disease |

**Do you have any other health issues or concerns that our staff should be made aware of?** _____

_____