Arctic New Patient Intake Paperwork

1 Patient Information

First Name: _____ Last Name: _____ Middle Name: _____

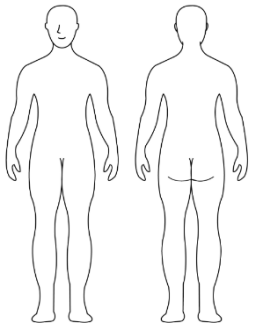
Email:_____ Primary Phone:_____ Legal Sex:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

2 Reason for coming in

Primary Reason for coming in:_____

Indicate where on the figure



How long have you experienced this?_____ Most recent occurrence date:_____

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning**

☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other:_____

Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_____

How often does the pain occur?_____ Does it seem to be getting progressively worse?: ☐ Yes ☐ No

What do you think caused the problem?_____

What activities make it worse?:_____ Worse in the morning or evening? _____

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to life object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/ OffChair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:_____

Rate the severity of you pain at its worst (1- Least to 10-Severe): _____ Least severe (when you feel it):_____ Present moment:_____

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:_____

What has helped/provided most relief?_____

3 Additional Concerns

Additional Concern 1:_____How long have you experienced this?_____

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness

☐ Swelling ☐ Other:_____ Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_____ How often does the pain occur?_____

What activities make it worse?:_____ Worse in the morning or evening? _____

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to life object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/Off Chair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:_____

Rate the severity of you pain at its worst (1- Least to 10-Severe): _____ Least severe (when you feel it):_____ Present moment:_____

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:_____

What has helped/ provided most relief?_____

Additional Concern 2 :_____ How long have you experienced this?_____

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness

☐ Swelling ☐ Other:_____ Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_____ How often does the pain occur?_____

What activities make it worse?:_____ Worse in the morning or evening? _____

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to life object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/Off Chair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:_____

Rate the severity of you pain at its worst (1- Least to 10-Severe): _____Least severe (when you feel it):_____ Present moment:_____

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:_____

What has helped/ provided most relief?_____

4 Family History

Please indicate if siblings, parents, or grandparents have a history of any of the following:

☐ Autoimmune Disease	☐ Cancer	☐ High Blood Pressure	☐ Osteoporosis
☐ Bleeding Disorder	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Clotting Disorder	☐ Heart Disease	☐ Migraines	☐ Thyroid Disease

☐ Family has no history of these conditions

5 Personal History

Please indicate if you have a history of the following:

☐ AIDS/HIV	☐ Diabetes	☐ MS
☐ Allergies	☐ Eating Disorder	☐ Osteoporosis
☐ Anemia	☐ Emphysema	☐ Pacemaker
☐ Anxiety/Depression	☐ Epilepsy/Seizure Disorder	☐ Parkinson's
☐ Appendicitis	☐ Headaches	☐ Pinched Nerve
☐ Arthritis (Osteo, Rheumatoid, etc.)	☐ Heart Disease	☐ Pneumonia
☐ Asthma	☐ Hepatitis	☐ Prostate Problem
☐ Autoimmune Disorder	☐ Hernia	☐ Psychiatric Care
☐ Bleeding Disorder	☐ Herniated Disk	☐ STD
☐ Bronchitis	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease
☐ Chemical Dependence/Alcoholism	☐ Liver Disease	☐ Tuberculosis
☐ Chicken Pox	☐ Migraines	☐ Tumors/Growths
☐ Clotting Disorder	☐ Mononucleosis	☐ Ulcers

☐ Patient has no history of these conditions

Are you Pregnant? ☐ Yes ☐ No ☐ Does Not Apply How Many Weeks?_____

You certify that you are NOT pregnant, and that Chiro One's staff has your permission to perform an X-ray evaluation, if medically necessary. You have been advised that X-ray can be hazardous to an unborn child. Date of last Period: _____

Patient Signature:_____ **Date:**_____

General PCP Name:_____ Phone Number:_____

Please enter the last known date and any notable findings:

Physical Exam:_____ Spinal X-Ray: _____ Spinal Exam: _____ Chest X-ray: _____

MRI: _____ CT-Scan: _____ Bone Scan: _____ Blood Test: _____ Urine Test: _____

Notable Findings:_____

Are you taking any Medications? ☐Yes ☐No List/Frequency:_____

_____

Do you take any vitamins or supplements?☐ Yes☐No List/Frequency:_____

_____

Previous Chiropractic Experience?☐Yes ☐No Last seen date/describe: _____

6 Life Activities

Occupation:_____ Employer/School:_____

Primary Work Activities: ☐ Sitting ☐Standing ☐ Light labor/lifting ☐Heavy labor/lifting ☐Repetitive motions

Previous Work Injuries (date/description): _____

Marital Status ☐Married/partnered ☐ Single ☐Widowed

Emergency Contact Name:_____ Phone:_____ Relationship to Patient: _____

Children Name/Age:_____ Did you give birth? ☐Yes ☐No

Please describe any complications during pregnancy:_____

Home Physical Activities:_____

Home Injuries (Date/Description):_____

Exercise:☐None☐Light☐Moderate☐Heavy Sport Activities (Prior/Current):_____

Sport Injuries (Prior/Current): _____

Habits: ☐Nicotine☐Alcohol☐Coffee/Caffeine Drinks☐High Stress Level ☐None How Often:_____

Sleep Hours/Night: _____

Please rank how your time is spent/ Personal Values (1- Most/ 6- Least)

____Family/Home ____Career/Financial ____Social/Friends _____Mental Health/Spiritual _____Fitness/Nutrition ____Sleep/Rest

7 Prior Traumas

Have you ever been in a Motor Vehicle Accident? ☐Yes☐No

Date of Accident:_____ Symptoms/Pain:_____ Treatment Received:☐Medical ☐Chiropractic ☐None

Details including speed of vehicle:_____

_____

Date of Accident:_____ Symptoms/Pain:_____ Treatment Received:☐Medical ☐Chiropractic ☐None

Details including speed of vehicle:_____

_____

Falls (Date/Describe):_____

Head Injuries (Date/Describe):_____

Dislocations (Date/Describe):_____

Broken Bones (Date/Describe):_____

Surgeries (Date/Describe):_____

8 Payment/Insurance Info

Who is financially responsible for this account? ☐Self ☐Other Name:_____ Relationship to patient:_____

Is the patient covered by insurance? ☐Yes ☐No Name of Insurance Company:_____

Who is the main/subscriber or policy holder? ☐Self ☐Other

Subscriber Name:_____ Relationship to Patient:_____ Subscriber Birth Date:_____

Is the policy associated with: ☐HSA ☐FSA ☐HRA ☐None

Is the patient covered by additional/secondary insurance? ☐Yes ☐No Name of Insurance Company:_____

Who is the main/subscriber or policy holder? ☐Self ☐Other

Subscriber Name:_____ Relationship to Patient:_____ Subscriber Birth Date:_____

9 Additional Clinical Comments

Clinical Comments: _____

Examiner's Name: _____ Examiner's Signature: _____ Date: _____

Physician/Provider Name: _____ Physician/Provider Signature: _____ Date: _____