

**NEW PATIENT INFORMATION**

**Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_  
**Last 4 of SS#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Zip:** \_\_\_\_\_

**Home #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**Ins. Carrier:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Subscriber:** \_\_\_\_\_

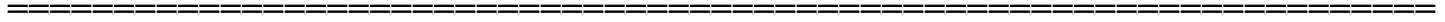
What is the reason for your visit today? \_\_\_\_\_

Have you been treated for this condition before? Yes No If so, when? \_\_\_\_\_

Is this a result of an accident / injury? Y / N

How did you hear about us?	Circle Yes or No		If yes please provide detail _____
	Yes	No	
Referring patient	Yes	No	_____
Phone Book	Yes	No	_____
Internet	Yes	No	_____
Insurance Company	Yes	No	_____
Direct Mail	Yes	No	_____
Other	Yes	No	_____

**Below to be filled out by office personnel:**



Patient Information entered into computer?	Yes	No
Insurance verified? (If applicable)	Yes	No
Treatment plan on file	Yes	No
Notes for Dr. Dent		
_____		
_____		
_____		

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation  
 General complaint

2. Circle on the drawings below where you have pain/symptoms

3. How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp  Numb  
 Dull  Tingly  
 Diffuse  Sharp with motion  
 Achy  Shooting with motion  
 Burning  Stabbing with motion  
 Shooting  Electric like with motion  
 Stiff  Other: \_\_\_\_\_

5. How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. Has the problem interfered with your work? If so, please specify severity.

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. Has the problem interfered with your social activities? If so, please specify severity.

- Not at all  A little bit  Moderately  Quite a bit  Extremely

9. Who else have you seen for your problem?

- Other Chiropractor  Neurologist  Primary Care Physician  
 ER physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  No one

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?

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12. Do you consider this problem to be severe?

- Yes  Yes, at times  No

13. What aggravates your problem?

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14. Does it prevent you from doing any activities? If so please elaborate

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15. Patient Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

16. How would you rate your overall Health?

- Excellent  Very Good  Good  Fair  Poor

17. What type of exercise do you do?

- Strenuous  Moderate  Light  None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis
- Heart Problems

- Diabetes
- Cancer

- Lupus
- ALS

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent
<b>Urination</b>					
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/
<b>Rash</b>					
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<b>For Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**20. List all medications you are currently taking (prescription and/or over-the-counter)**

\_\_\_\_\_

**21. List all surgical procedures / hospitalizations you have had:**

\_\_\_\_\_

**23. What activities do you do at work?**

<input type="checkbox"/> <b>Sit:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Stand:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Computer work:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>On the phone:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

**24. What activities do you do outside of work?**

\_\_\_\_\_

**26. Have you had significant past trauma?**  No  Yes

If yes, please elaborate:

\_\_\_\_\_

**27. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_