# CONFIDENTIAL PATIENT INFORMATION

**PLEASE PRINT** Today's Date: _____

Were you referred to a particular doctor? _____ Who referred you to this office? _____

LEGAL NAME: First _____ MI _____ Last _____

Name You Preferred to be called:_____ Sex: M / F Martial Status: M / S / D / W

Mailing Address_____City_____State_____Zip_____-_____

Date of Birth _____ Age _____ Social Security _____

Home Phone ( ) _____ Cell ( ) _____

Cell Phone Carrier _____ (Required if you want to receive appointment reminders via text message)

Employer_____ Work Phone ( ) _____

Email Address: _____

Spouse's Name _____Spouse's Employer _____Work Phone( )_____

Nearest Relative (not living with you)_____Home Phone( )_____ Work Phone( )_____

Address_____City_____State_____Zip_____-_____Relationship_____

EMERGENCY CONTACT: _____Relationship_____Phone( )_____

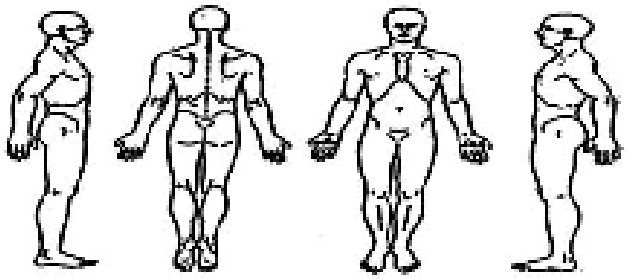
Are you claustrophobic? ☐ NO ☐ YES Any implanted metallic objects? ☐ NO ☐ YES Describe: _____

Do you have a Pacemaker or Defibrillator? ☐ No ☐ Yes Year received: _____

**Intake Questions:**

**1. Is today's problem caused by:** ☐ Auto Accident ☐ Workman's Compensation Date of Accident: _____

**2. Indicate on the drawings 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 ☐ Achy ☐ Shooting ☐ Burning ☐ Stiff
☐ Shooting with motion ☐ Sharp with motion ☐ Electric like with motion ☐ Stabbing with motion ☐ 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. How much has the problem interfered with your work?**
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

**8. How much has the problem interfered with your social activities?**
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

**9. Who else have you seen for your problem?**
☐ 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?** _____

_____

**12. Do you consider this problem to be severe?**
☐ Yes ☐ Yes, at times ☐ No

**13. What aggravates your problem?** _____

What makes it feel better? _____

**14. What concerns you the most about your problem; what does it prevent you from doing?** _____

_____

**15. What is your: 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 □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ 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.**

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

**20. List all of the over-the-counter medications and vitamins you are currently taking:** _____
_____

**21. List all surgical procedures you have had:** _____
_____

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

| | | | |
|---|---|---|---|
| □ **Sit:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Stand:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Computer work:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **On the phone:** | □ Most of the day | □ Half the day | □ A little of the day |

**23. What activities do you do outside of work?**
_____

**24. Have you ever been hospitalized?** □ No □ Yes
if yes, why _____

**25. Have you had significant past trauma?** □ No □ Yes

**26. Anything else pertinent to your visit today?**_____

**PAYMENT IS EXPECTED AT THE TIME OF VISIT!** Will you be paying today by: ☐ CASH ☐ CHECK ☐ CREDIT CARD

Are You Insured? ☐ NO ☐ YES Insurance Company:_____
IF YOU WOULD LIKE US TO HELP YOU FILE YOUR INSURANCE, WE MUST HAVE COPIES OF THE INSURANCE CARDS.

**I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that PROCOLUNA CHIROPRACTIC CARE will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to PROCOLUNA CHIROPRACTIC CARE will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that if PROCOLUNA CHIROPRACTIC CARE is not a provider for my insurance company they have the right not to accept assignment or file my insurance.**

Patient Signature:_____Date:_____

**Guardian's Signature (if under 18)**_____Date:_____