GONSTEAD FAMILY CHIROPRACTIC

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Date_____/_____/_____ S/S_____-_____-_____

First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____/_____/_____ Height_____ Weight_____ e-mail address:_____

Sex: ❒ Female ❒ Male **Status:** ❒ Minor ❒ Married ❒ Single ❒ Other

Your Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

Spouse/ Parent's Name_____ Phone_____

Who may we thank for referring you to us?_____

Person to contact in case of an emergency_____ Phone_____

HEALTH HISTORY

Do you currently have or have you previously had any of the following symptoms**:**

- ❒ Headaches
- ❒ Neck Pain
- ❒ Neck Stiffness
- ❒ Mid Back Pain
- ❒ Low Back Pain
- ❒ Arm Pain
- ❒ Leg Pain
- ❒ Pins and Needles in Arms
- ❒ Pins and Needles in Legs
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Cold Hands
- ❒ Cold Feet
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Mood Swings
- ❒ Sleeping Problems
- ❒ Fatigue
- ❒ Depression
- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ Cold Sweats
- ❒ Fever
- ❒ Fainting
- ❒ Dizziness
- ❒ Loss of Balance
- ❒ Light Sensitivity with Eyes
- ❒ Ringing/ Buzzing in Ears
- ❒ Loss of Memory
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Upset Stomach
- ❒ Constipation
- ❒ Diarrhea
- ❒ Urinary Problems
- ❒ Heartburn
- ❒ Ulcers
- ❒ Allergies
- ❒ Menstrual Pain
- ❒ Menstrual Irregularity
- ❒ Hot flashes

Have **YOU** (❍) or **A FAMILY MEMBER** (❒) ever been diagnosed with any of the following conditions**:**

- ❍ ❒ AIDS/HIV
- ❍ ❒ Cancer
- ❍ ❒ High Blood Pressure
- ❍ ❒ Heart Disease
- ❍ ❒ Diabetes
- ❍ ❒ Stroke
- ❍ ❒ None
- ❍ ❒ Unknown
- ❍ ❒ Other _____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT: (chief complaint)

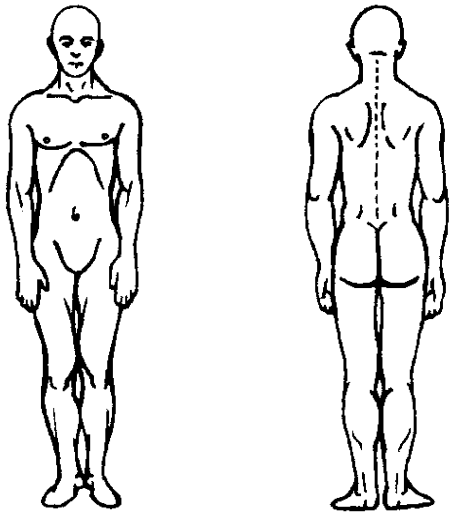
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain?_____

What activities are difficult to perform? ❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down

Please describe any other activities that are restricted due to this injury?_____

_____

When did you first notice these symptoms?_____ Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When?_____

Have you had an injury or fall? ❒ No ❒ Yes, Describe_____

Have you ever been diagnosed with a Subluxation? ❒ No ❒ Yes, When? _____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: ❒ None

_____

_____

Surgical History: _____ ❒ None

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

Which best describes your health goals: ❒pain relief only ❒correct entire problem ❒ wellness/ preventative care

DATE: _____/_____/_____ **SIGNATURE**: _____

PARENT/ GUARDIAN:_____