STAGECOACH FAMILY CHIROPRACTIC

INTAKE PAPERWORK Date: _____ Who referred you to our clinic? _____

PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____City: _____State: ____ Zip: _____

E-mail: _____Home Phone: _____Mobile Phone:_____
❑ I authorize my email and phone to be added to Stagecoach Family Chiropractic database for email, text alerts and product promotion

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and ages: _____

Emergency Contact Name: _____Relationship: _____Phone Number: _____

HISTORY OF COMPLAINT

1. Please list the condition(s) or health concerns you have: Primary: _____

Secondary: _____Third: _____Fourth: _____

2. When did the problem(s) begin? _____When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day

3. How long does it last? ☐ constant ☐ on and off during the day ☐ It comes and goes throughout the week

4. Is your problem the result of ANY type of accident? ☐ Yes ☐ No

If yes, identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____

Date of Accident: _____ / _____ / _____ Approximately what time that day? _____am _____pm

Have you reported this accident to anyone? ☐ No ☐ Yes if yes to whom: _____

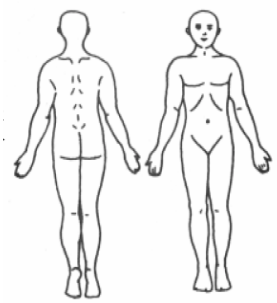
5. Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

If yes, when: _____ by whom? _____How long were you under care?_____

What were the results? _____

Name of Previous Chiropractor: _____ ☐ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/ Stabbing **T**=Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

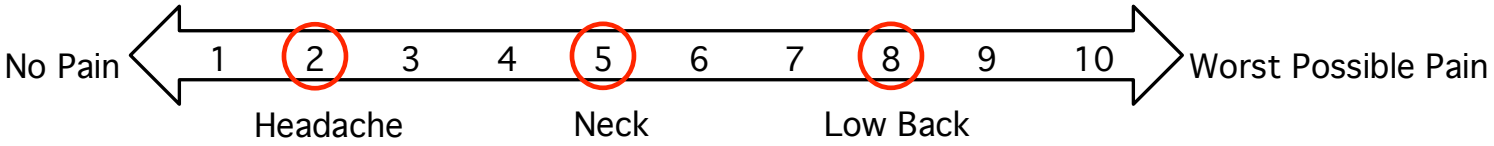
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

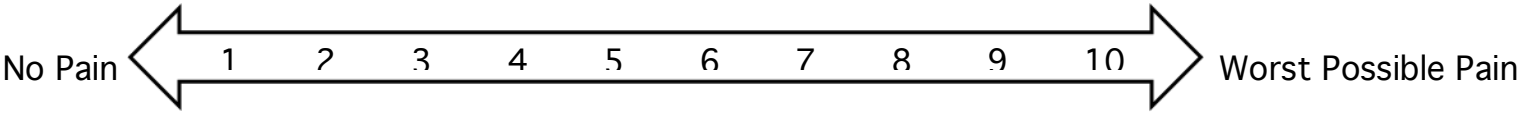
INTENSITY RATING

Please rate your pain: RIGHT NOW, ON AN AVERAGE DAY, WHEN IT"S NOT THAT BAD, AND WHEN IT IS WORST. If you have multiple conditions, please label as shown below.

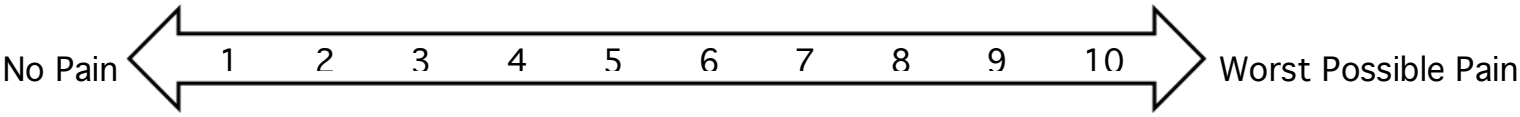
Example



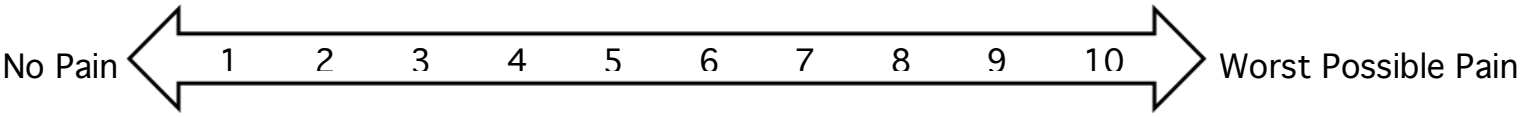
1. What is your pain **RIGHT NOW**?



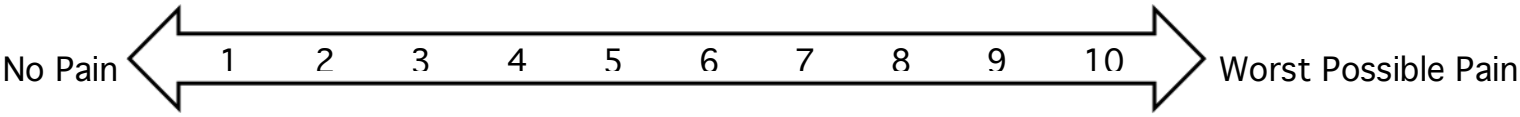
2. What is your **TYPICAL** or **AVERAGE** pain?



3. What is your pain level **AT ITS BEST** (How close to "no pain" are you when you have least amount of pain)?



4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



LIST PRESCRIPTION DRUGS YOU TAKE:

_____

_____

_____

LIST ALL SUPPLEMENTS/VITAMINS YOU TAKE:

_____

_____

_____

PAST HISTORY

1. Have you suffered with any of these or a similar problem in the past? ❑ No ❑ Yes , if yes:

How many times? _____ When was the last episode? _____ How did the injury happen?_____

2. Other forms of treatment tried: ❑ No ❑ Yes If yes, please state type of treatment: _____ provided by:?_____

How long ago? _____ What were the results: ❑ Favorable ❑ Unfavorable→ please explain:_____

ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Washing/Bathing/Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	

Please mark P for in the Past, C for Current, Leave Blank for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)
___ Broken Bone	___ Dislocation	___ Tumors	___ Fracture	___ Rheumatoid Arthritis
___ Diasbility	___ Cancer	___ Heart Attack	___ Osteo Arthritis	___ Diabetes

PAST HISTORY RELATED TO CURRENT CONDITION

Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	WHAT	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →				
SURGERIES →				
DISEASES →				

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of? ❑ No ❑Yes: _____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: occurs → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. **Hobbies -Recreational Activities-** Exercise: How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

5 Health Essentials Profile

1. Have you tested with high triglycerides or high cholesterol? **(Y / N)** Values?_____

2. Have you tested with high blood pressure? **(Y / N)**

3. Are you diabetic? **(Y / N)** Have you been diagnosed as pre-diabetic or with metabolic syndrome? **(Y / N)**

4. Do you eat breakfast daily from Monday to Friday? **(Y / N)**

5. How many days per week do you skip one meal? **(0) (1) (2) (3) (4+)**

6. How many fast food, refined foods, or pre-pared meals do you eat per week? **(0) (1-3) (4-6) (7+)**

7. How many servings of fruit do you have a day? **(0-1) (2-3) (4+)** How many servings of vegetables do you have a day? **(0-1) (2-3) (4+)**

8. Do you regularly drink sodas (1 or more every day)? (**Y / N)**

9. Current weight? _____ Target weight? _____

10. Are you regularly exposed to cleaning products or industrial chemicals? **(Y / N)**

11. Have you ever noticed mold growing or smell mildew in your home or your place of work? **(Y / N)**

12. Have you received a full standard profile of vaccinations? **(Y / N)**

13. Do you receive yearly flu shots? **(Y / N)** How many flu shots have you received? **_____ (estimate)**

14. Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? **(Y / N)**

15. Do you average less than 7 hours of sleep per night **(Y / N)**

16. Do you ever take pills to go to sleep or relax **(Y / N)**

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) _____

I hereby authorize payment to be made directly to Stagecoach Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Stagecoach Family Chiropractic for any and all services I receive at this office.

_____ _____ / _____ / _____

Patient or Authorized Person's Signature Date Completed

_____ _____ /_____ / _____

Doctor's Signature Date Form Reviewed