New Patient Intake

Anderson Family Chiropractic, SC
2911 Tower Ave, Ste 4
Superior, WI 54880

Date: / /

Patient Information:

First Name_____ **Preferred Name** _____

Last Name_____ **Middle Name** _____ **Suffix**_____

Home Phone_____ **Cell Phone**_____

Email_____ **DOB**_____/_____/_____ **Age**____

SSN_____ **Gender:** ☐ **Male** ☐ **Female**

Address:_____ **City/State/Zip**_____

_____

Ethnicity:

☐ Caucasian ☐ Hispanic
☐ African American ☐ Asian/Pacific Islander
☐ Native American ☐ Alaska Native
☐ Other:_____ ☐ Prefer not to answer

Language: _____

Marital Status:

☐ Single ☐ Married ☐ Other

Spousal Information:

Full Name_____
Phone_____
Address ☐ **same as above**

_____
_____

Employment Information: **Status** ☐ FT ☐ PT ☐ Unemployed ☐ Other_____

Employer_____ **Email**_____ **Type of Work**_____

Address _____ **Phone**_____

_____

Insurance Information:

☐ **Group** ☐ **Medicare** ☐ **Medical Assistance** ☐ **No Insurance (Cash)** ☐ **Health Savings Account**

Insurance Provider_____ **Member ID**_____

Group ID_____ **Phone**_____

Emergency Contact:

Name_____
Phone_____

Guarantor Info:

Name_____ **DOB**_____
Phone_____**Employer**_____

☐ **Option to Decline:** I have read and understand that if I choose not to provide any of the above information, my claim cannot be processed. I agree to be placed on a cash payment basis and my insurance will not be billed for my visit. Please sign below.

Signature_____ **Date**_____

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Health History:

Height_____ **Weight**_____

Major illnesses_____

Injuries/accidents_____

Major Surgeries_____

Additional Information_____

_____

_____

Chief Complaint:

Date Symptoms Began: _____/_____/_____

Complaint related to: ☐ **Workers Comp** ☐ **Auto Accident** ☐ **Chronic Discomfort**
☐ **Sports Injury** ☐ **Fall** ☐ **Home Injury** ☐ **Other**_____

Have you ever seen a chiropractor in the past? ☐ **Yes** ☐ **No** **Who?**_____

Have you reported to your employer, if work related? ☐ **Yes** ☐ **No**

Briefly describe your main complaint:

_____

_____

_____

Additional complaints:

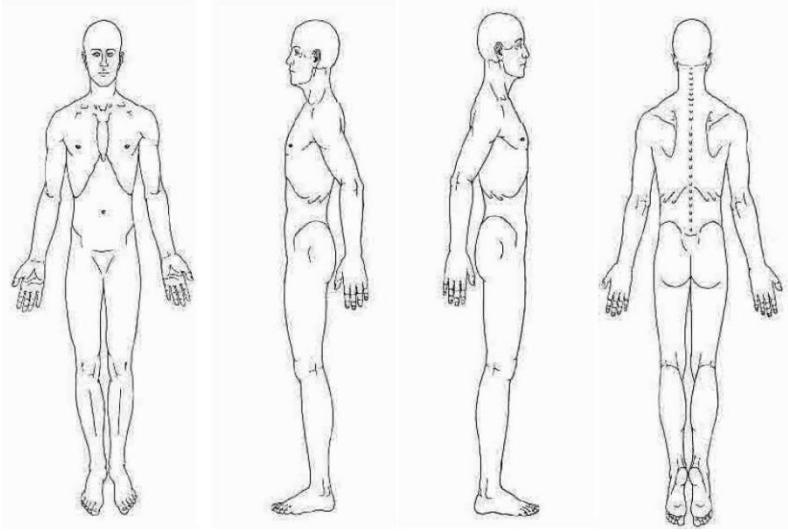
_____

_____

_____

Have you been treated by another chiropractor or physician for this problem? Who?

_____



In the diagram, circle area of complaint(s).
Describe type of pain by using symbols (below) in area of complaint:

T= tingling
S= stiff
A= achy
N= numbness
W= weak
G= stabbing
O= other

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	Current	Past
GENERAL		
Fever		
Sweats		
Fatigue		
Weight gain		
Weight loss		
Sleep disturbance		
NEUROLOGIC		
Seizures/epilepsy		
Stroke		
Tingling		
Numbness		
Weakness		
Difficulty Walking		
Poor coordination		
Lyme disease		
MUSCLE/BONE		
Joint pain		
Stiff		
Muscle ache		
Arthritis		
Bone pain		
Fracture		
Dislocation		
CONDITIONS		
Hypertension		
Diabetes		
High Cholesterol		
Heart condition		
Cancer/Tumor		
Parkinson's		
Multiple sclerosis		
Osteoporosis		
HIV/AIDS		
Thyroid Condition		
Gout		
MEDICATION		
Prescription		
Vitamin/Herbal Supplements		
Drug allergies		
Recreational drugs		

Please add additional information if applicable.

	Current	Past
MEDICAL HISTORY		
Substance abuse		
Allergies		
Hospitalization		
SOCIAL		
Consume alcohol		
Consume caffeine		
Smoker		
Exercise		
Drink_____glasses water /day		
Sleep____ hours/night		
OB/GYN (FEMALES)		
Pregnancy		
Mastectomy		
Lumps in breast		
Hot flashes		
Irregular periods		
FAMILY HISTORY		
Cancer		
Alcoholism		
Osteoporosis		
Depression		
Alzheimer's		
Heart disease		
Stroke		
PSYCHOLOGIC		
Excess Stress		
Depression		
Anxiety		

Please add additional information if applicable.

List Medications:_____

_____

_____

_____

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	Current	Past
HEAD		
Headache		
Dizziness		
Head trauma		
Fainting		
EYES		
Glasses/contacts?		
Change in vision		
Blurred vision		
Cataracts		
Sensitive to light		
Flashes in vision		
Spots in vision		
EARS		
Ringing in ears		
Hearing loss		
Ear pain		
Drainage		
Frequent infection		
NOSE		
Nose bleeds		
Sinus problems		
MOUTH		
Jaw Pain		
Sore throat		
Trouble Swallowing		
Recent dental work		
NECK		
Masses		
Stiffness		
Swelling		
LUNGS		
Difficulty breathing		
Asthma		
Pneumonia		
Cough		
Coughing blood		
Coughing phlegm		
Tuberculosis		

Please add additional information if applicable.

	Current	Past
VASCULAR		
Chest Pain		
Palpitations		
Ankle Swelling		
Cold feet/hands		
Hot feet/hands		
Calf pain		
G-I SYSTEM		
Heartburn		
Ulcers		
Nausea/vomiting		
Diarrhea		
Constipation		
Abdominal pain		
Liver disease		
G-U SYSTEM		
Difficulty urinating		
Pain urinating		
Blood in urine		
Foul urine odor		
Urinary infection		
Kidney stones		
Incontinence		
SKIN		
Rash		
Bruising		
Hair loss		
Brittle nails		
Itching		

Please add additional information if applicable.

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BOURNEMOUTH QUESTIONNAIRE

The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your pain?

   No Pain — Worst Pain Possible
   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No Interference — Unable to Carry Out Activity
   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

   No Interference — Unable to Carry Out Activity
   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at All Anxious — Extremely Anxious
   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at All Depressed — Extremely Depressed
   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

   Have Made it No Worse — Have Made it Much Worse
   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

   Completely Control it — No Control Whatsoever
   0 1 2 3 4 5 6 7 8 9 10