OPTIMAL SPINE
CHIROPRACTIC

Patient Intake Form

Date _____

First Name _____
Last Name _____
DOB _____
Sex ◯ Male ◯ Female
SSN _____
Address _____
City _____
State _____
Zip Code _____

Phone 1 _____
◯ Home ◯ Mobile ◯ Work ◯ Other
Phone 2 _____
◯ Home ◯ Mobile ◯ Work ◯ Other
Fax _____
Email _____
Employer _____
Employer Phone _____
Occupation _____

Job Status
◯ Not Employed ◯ Employed
◯ Part-Time Student ◯ Retired
◯ Full-Time Student

Marital Status
◯ Single ◯ Married ◯ Other

Receive Appointment Reminders
◯ Declined ◯ Voice ◯ Text ◯ Email

Height ___ ' ___ "
Weight _____ lbs

Reason For Visit: ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury ◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other _____

Referred By: ◯ Provider ◯ Friend ◯ Family ◯ Other _____
Referred By Name _____

How Heard of Us: ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website ◯ Advertisement ◯ Other _____

Demographics

Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or Other Specific Islander ◯ Other _____

Ethnicity: ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Unknown ◯ Other _____

Dominance: ◯ Right ◯ Left ◯ Ambidextrous

Emergency Contact Information

First Name _____
Last Name _____
Relationship _____
Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Depression	☐ Hernia	☐ Migraine Headaches	☐ Seizures
☐ Anemia	☐ Diabetes	☐ Herniated Disc	☐ Multiple Sclerosis	☐ Stroke
☐ Asthma	☐ Emphysema	☐ High Blood Pressure	☐ Osteoporosis	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Epilepsy	☐ High Cholesterol	☐ Pacemaker	☐ Tumors/Growths
☐ Bronchitis	☐ Fractures	☐ Immune Deficiency	☐ Parkinson's Disease	☐ Ulcers
☐ Cancer	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Other _____
☐ Fatigue	☐ Heart Disease	☐ Liver Disease	☐ Rheumatoid Arthritis	

Surgeries:

Traumas:

Complaint #1 _____

Does the pain travel anywhere else? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? _____

Frequency: ○ Intermittent ○ Occasional ○ Frequent ○ Constant _____ times per ○ Day ○ Week ○ Month ○ Year

Onset: Have had symptoms over the past _____ ○ Days ○ Weeks ○ Months ○ Years

Intensity: ○ Minimal ○ Slight ○ Moderate ○ Severe

Rate your pain: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Aggravating Factors: What makes the problem worse? ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ exercise ☐ going down stairs ☐ going from lying to sitting ☐ going from sitting to standing ☐ housework ☐ taking a deep breath ☐ lying down ☐ massage ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long time ☐ walking ☐ jogging ☐ lifting

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ walking ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching

What daily activities are affected due to the problem? ☐ caring for children ☐ climbing stairs ☐ doing laundry ☐ dressing ☐ driving ☐ exercising ☐ grooming ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ stretching ☐ yard work ☐ social/recreational activities ☐ toileting

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried ? ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic

Complaint #2 _____

Does the pain travel anywhere else?_____

Do you know what caused the problem?_____

Do you notice the pain during a certain time of day? _____

Frequency: ◯ Intermittent ◯ Occasional ◯ Frequent ◯ Constant _____ times per ◯ Day ◯ Week ◯ Month ◯ Year

Onset: Have had symptoms over the past _____ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Slight ◯ Moderate ◯ Severe

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Aggravating Factors: What makes the problem worse? ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ exercise ☐ going down stairs ☐ going from lying to sitting ☐ going from sitting to standing ☐ housework ☐ taking a deep breath ☐ lying down ☐ massage ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long time ☐ walking ☐ jogging ☐ lifting

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ walking ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching

What daily activities are affected due to the problem? ☐ caring for children ☐ climbing stairs ☐ doing laundry ☐ dressing ☐ driving ☐ exercising ☐ grooming ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ stretching ☐ yard work ☐ social/recreational activities ☐ toileting

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried ? ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic

Complaint #3 _____

Does the pain travel anywhere else?_____

Do you know what caused the problem?_____

Do you notice the pain during a certain time of day? _____

Frequency: ◯ Intermittent ◯ Occasional ◯ Frequent ◯ Constant _____ times per ◯ Day ◯ Week ◯ Month ◯ Year

Onset: Have had symptoms over the past _____ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Slight ◯ Moderate ◯ Severe

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Aggravating Factors: What makes the problem worse? ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ exercise ☐ going down stairs ☐ going from lying to sitting ☐ going from sitting to standing ☐ housework ☐ taking a deep breath ☐ lying down ☐ massage ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long time ☐ walking ☐ jogging ☐ lifting

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ walking ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching

What daily activities are affected due to the problem? ☐ caring for children ☐ climbing stairs ☐ doing laundry ☐ dressing ☐ driving ☐ exercising ☐ grooming ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ stretching ☐ yard work ☐ social/recreational activities ☐ toileting

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried ? ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic

Daily Habits

Do you smoke? ◯ Never smoked ◯ Unknown if ever smoked ◯ Unknown if currently smokes
◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker
If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ no ◯ light ◯ moderate ◯ heavy

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic

☐ Low (Time of Day) _____ ☐ High (Time of Day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ◯ None ◯ Low ◯ Moderate ◯ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? _____

Review of Systems

Musculoskeletal: Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis)

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations ☐ Persistent Coughing

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Stiffness ☐ Jaw Clicks ☐ Lumps

☐ Swollen Glands ☐ Trouble swallowing ☐ Other _____

Eyes: Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glaucoma ☐ Pain

☐ Vision Problems ☐ Other _____

Ears: Please check all that apply ☐ None

☐ Drainage ☐ Ear infections ☐ Poor balance ☐ Poor hearing ☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Itching ☐ Sinus pressure/pain ☐ Excessive mucus ☐ Other _____

Gastrointestinal: Please check all that apply ☐ None

☐ Change in appetite ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea

☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Vascular/Hematologic: Please check all that apply ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply ☐ None

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Neuralgia ☐ Memory confusion ☐ Weakness

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Other _____

Female:

Are you pregnant? ☐ Yes ☐ No Number of pregnancies _____

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Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date _____

Print Name of Patient, Parent, Guardian or Personal Representative