

Locke Chiropractic & Rehabilitation Center

New Patient Intake Form

Patient Data

Date _____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____

Sex: Male Female

Social Security Number: ____ - ____ - ____ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other _____

Spouse Data

First Name _____ Middle Initial ____ Last Name _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Employer Data

Name _____

Your Occupation _____ Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

Doctor's Signature _____

Patient Name _____ **Date** _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never
Other _____			

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other _____		

Occupational Activities: (Check one that best describes your job description)

Administration Business Owner Clerical/Secretary Computer User
Heavy Equipment operator Daycare/Childcare Construction Health Care
Food Service Industry Medium Manual Labor Manufacturing Home Services
Heavy Manual Labor Light Manual Labor Executive/Legal Housekeeper
Other _____

Doctor's Signature _____

Patient Name _____ **Date** _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	Respiratory			No	Allergic/			No
	Past	Presen			Past	Presen			Past	Presen	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and			No
Jaw Pain				Eyes			No		Past	Presen	
Irregular					Past	Presen		Difficulty			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred				Sore Throat			
	Past	Presen						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Presen		Sinus Infections			
Frequent				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Presen	
Lower Side Pain								Gall Bladder			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Presen		Constipation			
	Past	Presen		Thyroid				Liver Problems			

Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Presen		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Presen	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Presen		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty											

Please list all current medications being taken _____

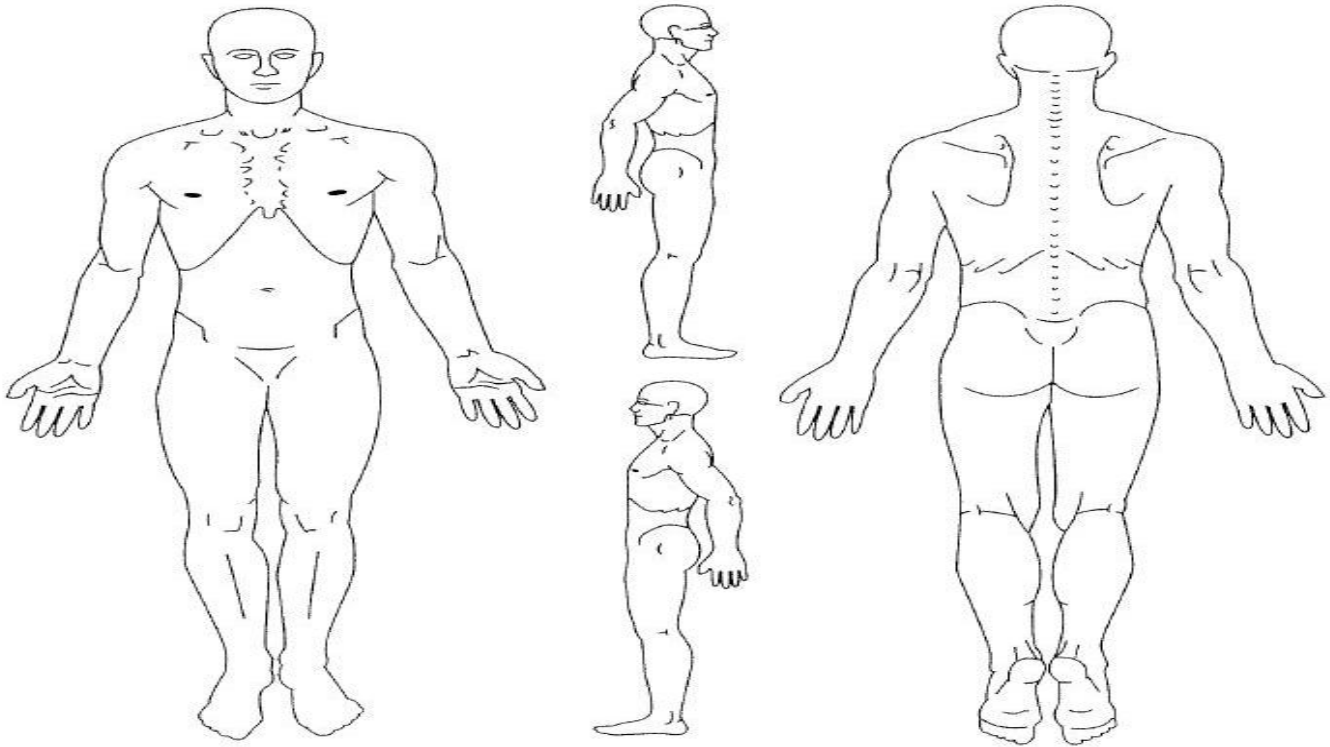
Doctor's Signature _____

Patient Name _____ **Date** _____

Are you pregnant? Yes _____ No _____ N/A _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly (76-100% of the day)	Frequently (51-75% of the day)	Occasionally (26-50% of the day)	Intermittently (0-25% of the day)
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What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Doctor's Signature _____

Patient Name _____ **Date** _____

How are your symptoms changing?

Getting worse

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____ am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date _____

SIGNATURE OF PHYSICIAN: _____ **Date:** _____