Discover Medical Center – Patient Intake Questionnaire

Patient Name: _____ Date of Birth: _____ Date: _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Email Address _____

Occupation _____ Employer _____

Emergency Contact _____ Phone Number _____

Referred by: _____ □ Google □ Local Ad □ Signage □ Other _____

Have you ever received Chiropractic Care? (Yes) (No) If yes, when? _____

A) Past Health History:

Surgeries: □ None Date of Surgery: Type of Surgery

_____ _____

_____ _____

_____ _____

Previous Injury or Trauma: _____

Broken bones/fractures? Which? _____

Allergies: _____

B) Family Health History: Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease

□ Diabetes □ Other _____ □ None of the above

C) Social and Occupational History:

Job description: _____ # Hours per Week: _____

Recreational / Hobbies: _____

D) Lifestyle:

Exercise: □ Never □ Seldom □ Week Ends □ Weekly □ Daily
Alcohol Use: □ Never □ Seldom □ Week Ends □ Weekly □ Daily
Tobacco Use: □ Never □ Seldom □ Week Ends □ Weekly □ Daily
Drug Use: □ Never □ Seldom □ Week Ends □ Weekly □ Daily

E) Medications: □ None

Medication Reason for taking

_____

_____

_____

_____

_____

_____

Patient Name: _____ Date: _____

Review of Systems: Have you had any of the issues related to the following?

Pulmonary (lung-related)
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Cardiovascular (heart-related)
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Neurological (nerve-related)
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Endocrine (glandular/hormonal)
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Renal (kidney-related)
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Gastroenterological (stomach-related)
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Hematological (blood-related)
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Dermatological (skin-related)
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Musculoskeletal (bone/muscle-related)
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Psychological
□ Psychiatric diagnosis □ Depression □ Suicidal thoughts □ Homicidal thoughts □ Bipolar disorder □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Oncological (cancer-related)
□ No □ Yes (please explain) _____

Females Only: Are you: Currently pregnant or think you may be pregnant? □ No □ Yes Breastfeeding? □ No □ Yes

Is there anything else in your past medical history that you feel is important to your care here? _____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Discover Chiropractic for services performed.

Patient or Guardian Signature _____ Date _____

History of Present Complaint

Patient Name: _____ Date: _____

(Please complete a form for **EACH** complaint individually)

Symptom 1: (Primary Complaint) _____

- Please rate this symptom on a scale from 0-10, (10 being the worst pain imaginable):

(Mild) (Moderate) (Severe)
0 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at this intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did this symptom begin **suddenly** or **gradually**? (circle one)
- When did this symptom begin? (Date or time-frame): _____
- What caused this symptom to begin? (Unknown) _____
- What makes this symptom **worse**? (circle **all** that apply):

(nothing) (any movement) (bending neck forward) (bending neck backward) (tilting head to the left) (tilting head to the right) (turning head to the left) (turning head to the right) (bending forward at waist) (bending backward at waist) (tilting left at waist) (tilting right at waist) (twisting left at waist) (twisting right at waist) (driving) (standing) (walking) (running) (lifting) (sitting) (getting up from seated position) (changing positions) (lying down) (reading) (working) (exercising) (laying on side in bed)

Other (please describe): _____

- What makes this symptom **better**? (circle **all** that apply):

(nothing) (rest) (ice) (heat) (stretching) (exercise) (walking) (pain medication) (muscle relaxers) (chiropractic) (massage) **Other** (please describe): _____

- Describe the **quality** of this symptom (circle **all** that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff

Other (please describe): _____

- Does this symptom radiate to another part of your body? (circle one): **(yes) (no)**

If yes, where does the symptom radiate? _____

- Is this symptom worse at certain times of the day or night? (please circle)

No difference Morning - Afternoon - Evening - Night - Other _____

- Treatment received for this condition and episode prior to today's visit? □ **Nothing**

☐ Chiropractic
☐ Physical Therapy
☐ Massage
☐ Stretching
☐ Anti-inflammatories
☐ Pain medication
☐ Muscle relaxers
☐ Trigger point injections
☐ Cortisone injections
☐ Surgery

Other _____

History of Present Complaint

Patient Name: _____ Date: _____

(Please complete a form for **EACH** complaint individually)

Symptom: (Other Complaint) _____

- Please rate this symptom on a scale from 0-10, (10 being the worst pain imaginable):

(Mild) (Moderate) (Severe)
0 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at this intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did this symptom begin **suddenly** or **gradually**? (circle one)
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Other (please describe): _____

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Patient Name: _____ Date: _____

(Please complete a form for **EACH** complaint individually)

Symptom: (Other Complaint) _____

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Other _____

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Patient Name: _____ Date: _____

(Please complete a form for **EACH** complaint individually)

Symptom: (Other Complaint) _____

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