Columbia Family Chiropractic Intake

At the moment, my pain is in….

☐ My back only ☐ My back and Rt. leg ☐ My back and Lt. leg ☐ My back and both legs
☐ My neck only ☐ My neck and Rt. arm ☐ My neck and Lt. arm ☐ My neck and both arms

How long have you had this problem? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 6-10 ☐ days ☐ weeks ☐ months ☐ years

Is your pain related to a home injury, work injury or car accident? Yes No

Pain changed in location or intensity lately? Yes No explain.._____

Is there any numbness or tingling? Yes No if yes, where?_____

Is there any weakness? Yes No if yes, where? _____

Increased pain when you cough / sneeze? Yes No if yes, where? _____

Increased pain when lifting? Yes No if yes, where? _____

Increased pain when you bend? Yes No if yes, where? _____

Increased pain when you stand or walk? Yes No if yes, where? _____

Increased pain when you sit in chairs? Yes No if yes, where? _____

Increased pain when you get up or down? Yes No if yes, where? _____

Had any loss of bowel or bladder control? Yes No

Had any numbness or tingling around the groin? Yes No

Does sitting down help your pain? Yes No

Does lying down help your pain? Yes No

How long can you stand without sitting? Less than… ☐ 5 min ☐10 min ☐ 15 min ☐ 30 min ☐ 1 Hr ☐ >1 Hr

How far can you walk? ☐ < 20 ft ☐ 20-100 ft ☐ about a block ☐ ¼ mile ☐ > a mile

Is this your first chiropractic experience? Yes No

Would you like us to inform your medical doctor of your visit? If yes, name of doctor _____

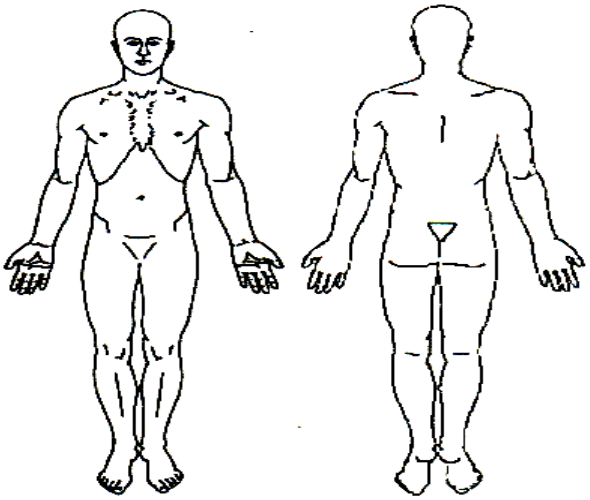
Have you had any of the following tests or treatments for this problem? ☐ X-Rays ☐ Bone Scan ☐ MRI ☐ CT ☐ EMG
☐ Blood Test ☐ Steroid Shots ☐ Medication ☐ Physical Therapy ☐ Pain Clinic

Does your pain affect your? ☐ Sleep ☐ Job ☐ Personal Care ☐ House Work

Do you have any metal implants, breast implants, surgical clips or pacemaker? Yes No

Are you right or left handed? R L

Show us where your pain is located, please note if the pain is, sharp, achy, numb, burning, tingling, stiffness, pressure



Columbia Family Chiropractic

Patient # _____

Page completed by:
__ patient __ nurse/MA
__ family __ physician
__ caretaker

New patients: Complete entire page.
Return patients: 1. Complete Symptoms section.
2. Update any changes to your medical, family, or social history below.
If no changes since your last visit here, no need to fill out those sections. Thank you.

Symptoms: Please circle any current symptoms.

General: fever, chills, fatigue, weight gain/loss (___lbs)

Eyes: redness, crusty, pain, itching, dry, watery, discharge, vision change, foreign body left/right/both

Ears: pain, discharge, ringing, clogged up left/right/both

Nose: congestion, runny, sinus pain, sinus pressure, nose bleed

Throat/: Mouth sore throat, stiff neck, swollen glands, ulcers, bad teeth

Skin: rash, itching, redness, swelling, hives, bruising, bite, mass/lump

Heart: chest pain, palpitations

Lungs: cough, wheezing, shortness of breath, tightness, painful breathing

Stomach: pain, nausea, vomiting, diarrhea, constipation, appetite change, blood in vomit, blood in stools, hemorrhoids

Other symptoms: _____

Urinary: pain, frequency, urgency, bloody urine

Female: irregular/heavy/missed/painful periods, itching, discharge, pelvic pain, breast lump

Male: discharge, scrotal/testicular mass, testicular pain

Muscles/: Bones muscle ache, joint pain, back pain, sprain, swelling, redness weakness, chest wall pain

Neuro: headache, dizziness, loss of consciousness, weakness, numbness tingling, migraines, seizures, memory trouble, radiating pain

Psychiatric: depression, anxiety, panic, difficulty sleeping, suicidal thoughts

Endocrine: energy loss, excessive hunger/thirst/urination, heat/cold intolerance

Blood/: Lymph swollen glands, unusual bruising/bleeding

Allergy: seasonal allergies , current allergic reaction

I have reviewed all of these symptoms and circled the ones that are current. There are no other current symptoms.

Signature: _____ Date: _____

Past Medical History

Asthma/COPD	Y / N
Diabetes	Y / N
Heart Disease	Y / N
High Blood Pressure	Y / N
Cancer	Y / N
Blood clot/PE	Y / N
Anxiety/Depression	Y / N
Genetic disease	Y / N

Other:_____

Surgery: ___Appendix ___Gallbladder ___Heart
___Tonsils Other: _____

Family Medical History

Asthma/COPD	Y / N
Diabetes	Y / N
Heart Disease	Y / N
High Blood Pressure	Y / N
Cancer	Y / N
Blood clot/PE	Y / N
Anxiety/Depression	Y / N
Genetic disease	Y / N

Other:_____

Social History

Employer: _____
Student? Y / N
Smoking? Y / N How many packs per day? _____
Alcohol use: __never __occasional __moderate __heavy
Street drugs: Y / N _____

Columbia Family Chiropractic

2003 West Broadway, Suite 100, Columbia, MO 65203

Patient #_________________________

Patient Last Name____
First Name____
Middle Initial___________
Sex___________________
Previous Last Name____
Date of Birth____
Social Security Number____

Address____ **College students please use your permanent mailing address.**
Address Line 2____
Zip__________________________
City _______________________________________
State_______________________________________

Best Phone Number (HOME)_____________________________________ MOBILE_________________________________
Email____
Language____
Race____________________________
Ethnicity__________________________________
Marital Status_____________________________

<u>POLICY HOLDER'S NAME AS IT APPEARS ON INSURANCE CARD</u> (This could be the parent, a spouse or legal guardian.)

Relationship to patient ____Self _____Spouse ____Parent ____Other
Last Name____
First Name____
Middle Initial _______________

Address____
Address Line 2____
Zip ______________________________
City____
State_______________________________________

Social Security Number ____
Date of Birth ____
Sex_________________

Phone Number of Policy holder____
Email of Policy holder____

*** ***

I have been offered and/or read a copy of the financial responsibility, assignment of insurance benefits, authorization to release and receive information and the HIPAA - privacy policy at Columbia Family Chiropractic, and have been given the right to read it in full before signing this form. A photocopy of assignments and authorization and my signature below is to be considered as valid as the original. By signing below, I agree to and accept these terms.

Signature X____ Date
X____

(Patient or Responsible Party)