Carmack Chiropractic and Sports Therapy

PATIENT INFO

Name:
(LAST) (MI) (FIRST)

Address:
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / /

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address:
(STREET) (CITY) (STATE) (ZIP)

Referred By: Primary Care Physician:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / /

Insurer's Employer:

Person responsible for account:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature **Date:**

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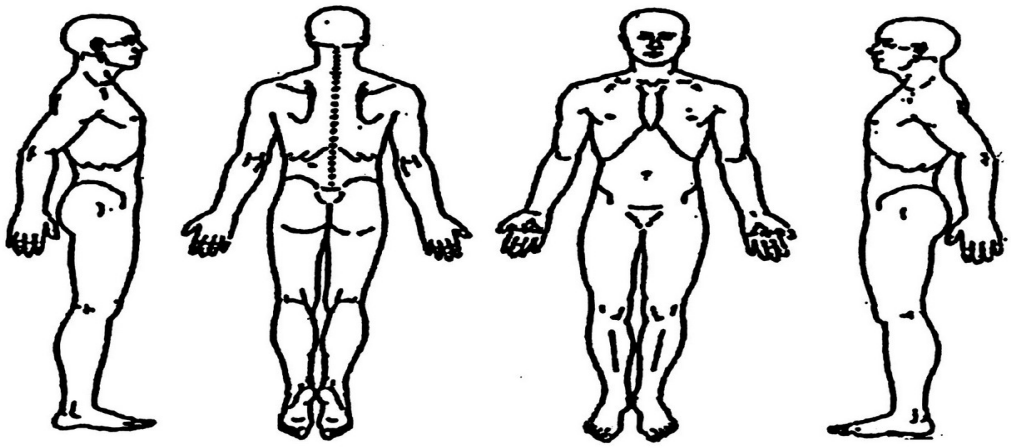
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem will be filed as: □ Insurance/ Self Pay □ Auto Accident

2. What is your primary area of concern/ pain? _____

3. Indicate on the drawings below where you have pain/symptoms: Tap diagram to mark pain online



4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric-like with motion
□ Other: _____

5. How long have you had this problem? _____

6. How do you think your problem began? _____

7. How often do you experience your symptoms?

□ Constantly (76-100% of the Time)
□ Occasionally (26-50% of the Time)
□ Frequently (51-75% of the Time)
□ Intermittently (1-25% of the Time)

8. On a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

□ Getting worse □ Staying the same □ Getting better

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12. What is your: Height _____ **Weight** _____ **Date of Birth** _____

Occupation _____

13. How would you rate your overall health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

14. Rate your level of exercise activity:
□ Strenuous □ Moderate □ Light □ None

15. Indicate if you suffer from or have immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

16. For the conditions listed below, please check the 'past' column if you have had the condition in the past; If you presently have a condition listed below, please check the 'present' column.

Past	Present		Past	Present		Past	Present
□	□ Headaches		□	□ High Blood Pressure	□	□	Diabetes
□	□ Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□ Upper Back Pain		□	□ Chest Pains		□	□ Frequent Urination
□	□ Mid Back Pain		□	□ Stroke		□	□ Tobacco Use
□	□ Low Back Pain		□	□ Angina		□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain		□	□ Kidney Stones		□	□ Allergies
□	□ Elbow/Upper Arm Pain		□	□ Kidney Disorders	□	□	Depression
□	□ Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□ Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□ Hip Pain		□	□ Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□ Upper Leg Pain		□	□ Prostate Problems	□	□	HIV/AIDS
□	□ Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□ Ankle/Foot Pain		□	□ Loss of Appetite		**Females Only**	
□	□ Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□ Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□ Arthritis		□	□ Hepatitis	□	□	Pregnancy
□	□ Rheumatoid Arthritis		□	□ Liver/Gall Bladder Disorder			
□	□ Cancer		□	□ General Fatigue			
□	□ Tumor		□	□ Muscular Incoordination			
□	□ Asthma		□	□ Visual Disturbances			
□	□ Chronic Sinusitis		□	□ Dizziness			

17. List all prescription and over-the-counter medications you are currently taking:

_____

_____

18. List all nutritional supplements you are currently taking:

_____

_____

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19. List all surgical procedures you have undergone:

_____

_____

20. What activities do you do at work?

Sit	□ Most of the day	□ Half of the day	□ A little of the day
Stand	□ Most of the day	□ Half of the day	□ A little of the day
Computer Work	□ Most of the day	□ Half of the day	□ A little of the day
On the Phone	□ Most of the day	□ Half of the day	□ A little of the day
Drive	□ Most of the day	□ Half of the day	□ A little of the day
Other Activities	□ Perform manual labor	□ Read a lot	□ Travel frequently

21. What activities do you enjoy outside of work?

_____

22. Have you ever been hospitalized? □ Yes □ No

If yes, why? _____

23. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? □ Yes □ No

If yes, what and when? _____

24. Is there anything else you wish to let the doctor know about your visit today? □ Yes □ No

If yes, what? _____

Patient Signature _____ **Date** _____