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New Patient Intake Form

Name_____ Date_____
Address_____City_____ State_____ Zip_____
Home Phone (_____)_____Cell Phone(_____)_____Date of Birth_____ Age_____
Referred by_____Social Security #_____
Occupation_____ Employer_____
Marital Status S M D W Spouse Name_____
Number of Children/Ages_____ Spouses Occupation_____
Are you covered by Medicare? Yes / No (If you are over the age of 65, you are automatically covered)

Have you ever received Chiropractic Care? Yes No
(if Yes) When/where?_____

About Your Health

Please circle for each of the following:			Patient Comment If answer is Yes	Chiropractor's Comments
Current Health Habits:				
Did/do you smoke?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/Mental stress?	Y	N	_____	_____
Hobbies/Sports injuries?	Y	N	_____	_____
Have you been in accidents/trauma?	Y	N	_____	_____
			_____	_____

Symptoms and Present State of Health:
Revyve Chiropractic is committed to maintaining the health and integrity of the spine and nervous system. Pain and other symptoms are the body's way of communicating a loss of function. Please describe any symptoms or complaints you are experiencing so that the doctor may address them.

Major Complaint:
Pain/Problem:_____

Was there a trauma or other incident that caused your complaint? Yes / No / Unknown
Explain:_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness, tingling, or weakness in any area of your body? Where?_____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition progressively getting better, worse, or staying the same? _____

Please Circle where you're at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other Doctors seen for this condition_____
Other complaints:
_____

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Please mark any of the following that you have now or have experienced in the past:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Irritability	O Cancer
O Tension	O Depression	O Diabetes
O Lights Bother Eyes	O Loss of Memory	
O Dizziness	O Change in bowel or bladder activity	
O Joint Swelling	O Shortness of Breath	
O Unexpected Weight Loss	O Loss of Smell or Taste	
O Loss of Balance	O Concussions/Loss of consciousness	

Comments:_____

Have you been diagnosed with any medical conditions? Yes No
If Yes, please list:_____

What Medications are you taking?

_____

Have you had any surgeries? If so, please list

_____

Family Health History

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Comments:_____

What are your goals for Chiropractic care? (e.g., increased range of motion, decreased pain levels, injury prevention, general health and wellness, increased performance of job/sport/activities of daily life, etc.):_____

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 do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient Signature_____Date_____

Legal Guardian (if patient is under 18):
Printed Name:_____ Signature:_____ Date:_____