Chiropractic Intake Form

PATIENT INFORMATION

Date: _____
Patient Name: _____
Last Name
_____
First Names Middle Initial
Social Security Number: _____
Address: _____
City: _____
State: _____ Zip code: _____
Home Phone: _____
Cell Phone: _____
Email: _____
Sex ☐M ☐F Age: _____
Birthday: _____
☐Married ☐Widowed ☐Single ☐Minor
☐Separated ☐Divorced ☐Other
Patient Employer/School: _____
Occupation: _____
Employer/School Address: _____
_____
Employer/School Phone: _____
Spouse Name: _____
Birthday: _____
Spouse's Employer: _____
Spouse's Work Number: _____
Spouse's Cell Phone: _____

IN CASE OF EMERGENCY CONTACT

Name: _____
Relationship: _____
Home Phone: _____
Cell Phone: _____
Whom may we thank for the referral: _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐No Date: _____
Type of accident ☐Auto ☐Work ☐Home ☐other
To whom have you made a report of your accident?
☐Auto insurance ☐Employer ☐Worker Comp

Who is responsible for this account? _____
Relationship to patient: _____
Insurance Co.: _____
Group Number: _____
Subscriber's Name: _____
Birthday: _____ SS#:_____
Is the Patient covered by additional insurance? ☐Yes ☐No
Insurance Co.: _____
Group Number: _____
Subscriber's Name: _____
Birthday: _____ SS#:_____
Relationship to patient: _____

ASSIGMENT AND RELASE
I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company
And assign directly to Dr. Randall G. Dreessen, D.C.,CCSP
All insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions.

The above-names doctor may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose for obtaining payment for services and determining insurance benefits or the benefits payable to related services. The consent will end when my current treatment plan is completed or one year from the date signed below

_____
Signature for patient, Parent, Guarding, Personal Representative

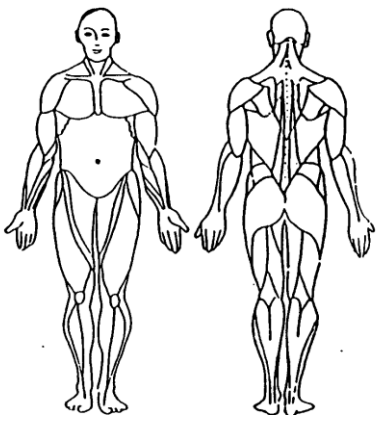
_____
Please print patient, Parent, Guarding, Personal Representative

_____ _____
Date Relationship to patient

PATIENT CONDITION

Reason for the visit: _____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark on X on the picture where you continue to have pain, numbness, for tingling
Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain)_____
Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness
☐Aching ☐Shooting ☐Burning ☐Tingling
☐Cramps ☐Stiffness ☐Swelling ☐Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation.
Activities or movements that is painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Laying Down



HEALTH HISTORY

What treatment have you already received for the condition ☐Medications ☐Surgery ☐Physical Therapy
☐Chiropractic service ☐None ☐Other _____

Name and Address of other doctor(s) who have treated your condition _____

Date of Last: ☐Physical Exam _____ ☐Spinal X-Ray _____ ☐Blood Test _____
☐MRI, CT-Scan, Bond Scan _____

Place a Mark on "YES" or "NO" to indicate if you have had any of the following

AIDS/HIV	☐Yes	☐No	Diabetes	☐Yes	☐No	Measles	☐Yes	☐No	Prosthesis	☐Yes	☐No
Alcoholism	☐Yes	☐No	Emphysema	☐Yes	☐No	Migraine	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Allergy Shots	☐Yes	☐No	Epilepsy	☐Yes	☐No	Headaches					
			Fractures	☐Yes	☐No	Miscarriage	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Anemia	☐Yes	☐No	Glaucoma	☐Yes	☐No	Mononuc-leosis	☐Yes	☐No	Stroke	☐Yes	☐No
Anorexia	☐Yes	☐No	Goiter	☐Yes	☐No				Thyroid Problems	☐Yes	☐No
Appendicitis	☐Yes	☐No	Gout	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No			
Arthritis	☐Yes	☐No	Heart Disease	☐Yes	☐No				Tonsillitis	☐Yes	☐No
Asthma	☐Yes	☐No				Mumps	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Hepatitis	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Tumors, Growths	☐Yes	☐No
			Hernia	☐Yes	☐No	Pacemaker	☐Yes	☐No			
Breast Lump	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Parkinson's Disease	☐Yes	☐No	Typhoid Fever	☐Yes	☐No
Bronchitis	☐Yes	☐No	Herpes	☐Yes	☐No	Pinched Nerve	☐Yes	☐No	Ulcers	☐Yes	☐No
Bulimia	☐Yes	☐No	High Cholesterol	☐Yes	☐No				Whopping Cough	☐Yes	☐No
Cancer	☐Yes	☐No				Pneumonia	☐Yes	☐No			
Cataracts	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Polio	☐Yes	☐No	Other _____		
Chemical Dependency	☐Yes	☐No				Prostate Problems	☐Yes	☐No	_____		
			Liver Disease	☐Yes	☐No				_____		
Gonorrhea	☐Yes	☐No									

EXERCISE
☐None
☐Moderate
☐Daily
☐Heavy

WORK ACTIVITY
☐Sitting
☐Standing
☐Light Labor
☐Heavy Labor

HABITS
☐Smoking Packs/day _____
☐Alcohol Drinks/Week _____
☐Coffee/Caffeine drink Cups/Day_____
☐High stress level Reasons _____

Are you pregnant? ☐Yes ☐No Due Date: _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERB/MINERALS