BodyMind Chiropractic Center
Confidential Patient Record

Patient Intake Form

Personal Information

Name: ____ Date: _______________

Address: _____________________________ City: _________________ State:____________ Zip: __________

Phone: Home: _______________________ Work: _____________________ Cell: _____________________

Preferred # to contact between 9AM & 5PM: Home Work Cell Email:______________________________

Social Security #: ___________________________________ Birth Date: __________/_________/_________

Employer: _____________________________________ Type of Work: _________________________________

Check One: ☐ Married ☐ Partner ☐ Single ☐Separated/Divorced

Name of Spouse/Partner: _____________________________________

Emergency Contact: ________________________ Phone: _________________ Relationship: _____________

Referred to this office by: ____

Have you ever been to a chiropractor before: ☐ Yes ☐ No Name of Chiropractor: _____________________

If Yes: What did you like about it?: ____

What did you not like about it?: ____

If No: Do you have any concerns about being here?: ____

Current Health Condition

Purpose of this visit: ____

____

____

When did this condition begin?: __________________ Have you had it before?: ☐ Yes ☐ No When?: ______

Have you seen other doctors for this condition?: ☐ Yes ☐ No Dr's Name: ______________________________

Treatment: ____

Results: ____

What activities aggravate the condition?: ____

Is there anything that helps?: ____

Is this condition getting worse? ☐ Yes ☐ No ☐ Comes and Goes ☐ Constant

Is it worse at a certain time of day? ☐ Yes ☐ No Time: ____________________

Is this condition interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other ___________________________

Is this conditions ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other ______________________

Did this condition come on slowly over time? ☐ Yes ☐ No ☐ Other ___________________________________

Please indicate on the diagram the areas of your discomfort

Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder/Arm Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip/Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Foot/Ankle Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain
____

Past Medical History

The following health history questions may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully as these problems can affect your overall course of care.

Surgeries: ____

Significant Trauma: ____

Allergies (drugs, chemicals, foods) ____

Occupational Stresses (chemical, physical, psychological, etc) ________________________________

Significant Illnesses: Check any of the following you have had:

☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Arthritis ☐ Migraine ☐ Thyroid

☐ Carpal Tunnel ☐ TMJ ☐ Anxiety ☐ Eczema ☐ Cancer ☐ Anemia

☐ PMS ☐ Digestive ☐ Other:_______________ ☐ Other: ________________

Medications

Please indicate the medications you are currently taking.

Name	Dosage	Purpose

Medical Symptoms Questionnaire

Name: ____ Date: ___________

Rate each of the following symptoms based upon your typical health profile for the past 30 days

Point Scale:
0 – Never/almost never have the symptoms
1 – Occasionally have it, effect is *not* severe
2 – Occasionally have it, effect is severe
3 – Frequently have it, effect is *not* severe
4 – Frequently have it, effect is severe

Head
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
_____TOTAL

Eyes
_____Watery or itchy
_____Swollen, reddened, or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
_____TOTAL

Ears
_____Itchy
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____TOTAL

Nose
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
_____TOTAL

Mouth/Throat
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen/discolored tongue, gums, lips
_____Canker sores
_____TOTAL

Skin
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating
_____TOTAL

Heart
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain
_____TOTAL

Lungs
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing
_____TOTAL

Digestive Tract
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching, passing gas
_____Heartburn
_____Intestinal/Stomach pain
_____TOTAL

Joints/Muscle
_____Pain or aches in joints
_____Arthritis
_____Stiffness or limitation of movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness
_____TOTAL

Weight
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight
_____TOTAL

Energy/Activity
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
_____TOTAL

Mind
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Poor physical coordination
_____Difficulty in making decisions
_____Stuttering or stammering
_____Slurred speech
_____Learning disabilities
_____TOTAL

Emotions
_____Mood swings
_____Anxiety, fear, nervousness, stress
_____Anger, irritability, aggressiveness
_____Depression
_____TOTAL

Other
_____Frequent illness
_____Frequent or urgent urination
_____Genital itch or discharge
_____TOTAL

GRAND TOTAL ___________

Lifestyle

Describe your exercise activities and frequency:

____

____

____

Describe your typical diet:

____

____

____

Vitamins: ____

		Quantity
Coffee Intake	☐ Yes ☐ No	____________
Alcohol Consumption	☐ Yes ☐ No	____________
Cigarettes	☐ Yes ☐ No	____________
Recreational Drugs	☐ Yes ☐ No	____________

Family Medical History

Please indicate which family members have had any of the following diseases (M-Maternal; P-Paternal)

Diabetes: ____

Cancer (indicate type): ____

High Blood Pressure: ____

Heart Disease: ____

Stroke: ____

Autoimmune: ____

Asthma: ____

Allergies: ____

Alcoholism: ____

Parkinson's/Alzheimer's: ____

Depression/Anxiety: ____

Other: ____

I hereby authorize the doctor to treat my condition as he or she deems appropriate. 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, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: ________________________ **Legal Guardian:** ________________ **Date:**_____________