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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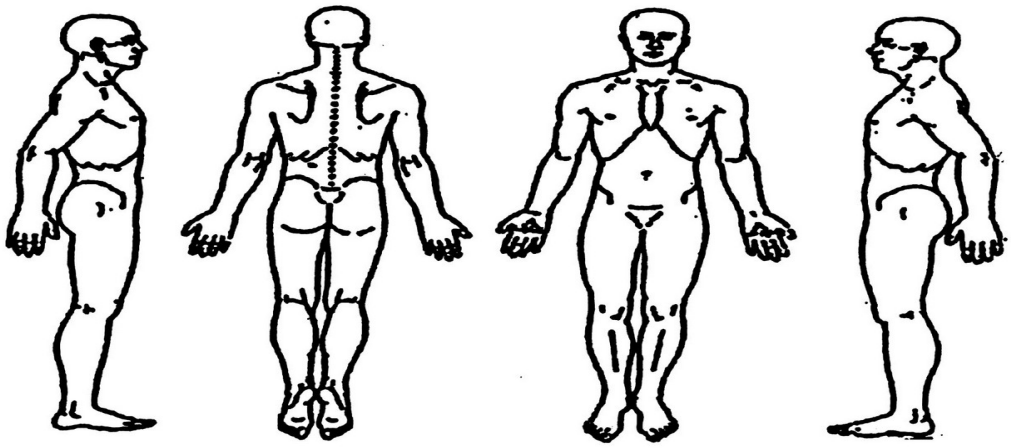
PATIENT INTAKE FORM

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

Health history

12. 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. Do you or any immediate family members have any of these conditions?

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

16. Check Past or Present for each condition that applies. You may check both.

Condition	Past	Present
Headaches	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Elbow/Upper Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Joint Pain/Stiffness	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Tumor	☐	☐
Asthma	☐	☐
Chronic Sinusitis	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Chest Pains	☐	☐
Stroke	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney Disorders	☐	☐

Condition	Past	Present
Bladder Infection	☐	☐
Painful Urination	☐	☐
Loss of Bladder Control	☐	☐
Prostate Problems	☐	☐
Abnormal Weight Gain/Loss	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver/Gall Bladder Disorder	☐	☐
General Fatigue	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐
Tobacco Use	☐	☐
Drug/Alcohol Dependence	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Epilepsy	☐	☐
Dermatitis/Eczema/Rash	☐	☐
HIV/AIDS	☐	☐
Females Only		
Birth Control Pills	☐	☐
Hormonal Replacement	☐	☐
Pregnancy	☐	☐

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

_____

18. List all nutritional supplements you are 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** _____