Chiropractic Intake Questionnaire

Preliminary questions:

Are you Medicare eligible?

- ❏ Yes
- ❏ No

Are you Medicaid eligible?

- ❏ Yes
- ❏ No

Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?

- ❏ Yes
- ❏ No

Is this visit related to any other accident or injury?

- ❏ Yes
- ❏ No

I am not enrolled with any insurance carrier other than Medicare. Do you plan on submitting a claim to your insurance? (If you don't have health insurance, select "No")

- ❏ Yes
- ❏ No

****** IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE STOP NOW AND CONTACT THE OFFICE.******

Are you seeking maintenance, wellness, or preventative treatment?

- ❏ Yes
- ❏ No, I have a health problem I would like to address

Are you interested in a nutritional evaluation?

- ❏ Yes
- ❏ No
- ❏ Maybe, give me more information

Are you interested in meridian therapy?

- ❏ Yes
- ❏ No
- ❏ Maybe, i would like more information
- ❏

How did you find out about Simply Chiropractic?

- ❏ Online search engine (Google, Bing, Yahoo, etc)
- ❏ Facebook
- ❏ Doctor
- ❏ Friend or family member
- ❏ Other (please specify) _____

Patient Name_____ Date of birth: _____ Age_____

Addressing your primary complaint

Please be as descriptive as possible.

If you do not have a complaint and are here for maintenance, preventative, or wellness care, please skip directly to the general health section.

What is your primary complaint? (If you don't have one, please enter "none" and skip directly to the Past Medical History section)

_____
_____
_____

What caused the onset?

_____

When did It start?

_____

On scale from 1 to 10, please rate the severity of your pain complaint. 0 means no pain, 10 is the WORST pain you have EVER experienced.

- ❏ 0-no pain
- ❏ 1-maybe and itch
- ❏ 2-paper cut
- ❏ 3-annoying
- ❏ 4-I can work, but something is wrong
- ❏ 5-bee sting
- ❏ 6-many bee stings
- ❏ 7-can't stop crying
- ❏ 8-can't move, too painful
- ❏ 9-mauled by a bear
- ❏ 10-need ambulance now

How would you describe the sensation of your complaint?

- ❏ Sharp pain
- ❏ Shooting
- ❏ Numbness
- ❏ Tingling
- ❏ Dull ache
- ❏ Burning
- ❏ Throbbing
- ❏ Other: _____

Does the complaint radiate or travel?

- ❏ Yes: If so, where?_____
- ❏ No

What makes the pain worse? (check all that apply)

- ❑ Bending
- ❑ Lifting
- ❑ Standing
- ❑ Twisting
- ❑ Sitting
- ❑ Walking
- ❑ Other: _____

What makes the pain feel better?

- ❑ Rest
- ❑ Medication
- ❑ Standing
- ❑ Ice
- ❑ Stretching
- ❑ Walking
- ❑ Heat
- ❑ Laying down
- ❑ Massage
- ❑ Sitting
- ❑ Other: _____

What does the pain interfere with? (check all that apply)

- ❑ Putting on shoes and socks
- ❑ Sleeping
- ❑ Looking over shoulder
- ❑ Job duties
- ❑ Household chores
- ❑ Washing hair
- ❑ Hobbies
- ❑ Getting dressed
- ❑ Climbing stairs
- ❑ Intercourse
- ❑ Other: _____

How often do you experience this complaint?

- ❑ Constantly (100%)
- ❑ Frequently (75%)
- ❑ Occasionally (50%)
- ❑ Intermittently (25%)
- ❑ Rarely (less than 25%)

Does your complaint worsen?

- ❑ Yes
- ❑ No

If so, When?

- ❑ Morning
- ❑ Night
- ❑ Work
- ❑ Midday
- ❑ Sleep
- ❑ Other: _____

Since the onset of your complaint how has it been changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

How much has the complaint interfered with your normal work? (including both work outside the home, and housework)

- ❑ Not at all
- ❑ Moderately
- ❑ Extremely
- ❑ A little bit
- ❑ Quite a bit

How much would you say this complaint has affected your social activities?

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ A little of the time
- ❑ None of the time

Have you seen any other medical provider for your current complaint?

- ❑ Yes
- ❑ No

If yes, what did they say was wrong?

_____
_____
_____

Please list any other current health symptoms or health complaints you are currently experiencing.

_____
_____
_____

Past Medical History

Please describe your past medical history:

_____
_____
_____
_____

Poor posture leads to poor health and often indicates a spinal problem.

How would you rate your posture? (Please circle)

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Stress can cause or accelerate spinal damage.

Rate your stress level over the last 90 days.

Low 1 2 3 4 5 6 7 8 9 10 High

Prescription medications and surgeries may cause various side effects, hide the severity of health problems and hinder the body's ability to heal.

Please list all your current medications and reasons for taking them:

_____
_____
_____
_____

Please list all of your past surgeries, including estimated dates:

_____
_____
_____
_____

Please list hospitalizations, reasons for them, and approximate dates:

_____
_____
_____
_____

Have you had any x-rays or other diagnostic imaging done in the past year?

- ❑ Yes
- ❑ No

Have you had any lab work done in the past year?

- ❑ Yes
- ❑ No

Is there any chance that you are pregnant?

- ❑ Yes
- ❑ No
- ❑ N/A

Do you have a pacemaker?

- ❑ Yes
- ❑ No

Do you have any metal implants or devices?

- ❑ Yes
- ❑ No

How many times have you visited a chiropractor in your lifetime?

- ❑ I go all the time
- ❑ I used to go all the time, but it's been a while
- ❑ More than 10 times
- ❑ Up to 10 times
- ❑ Once or twice
- ❑ Never

Is there anything else about your history or current condition that you feel is important to mention?

_____
_____
_____

Social History

Do you smoke?

- ❏ Yes
- ❏ I used to smoke, but I quit
- ❏ I only smoke once in a while
- ❏ I have never smoked
- ❏ I vape

Do you drink alcohol?

- ❏ Yes
- ❏ Yes, socially
- ❏ Yes, but only on weekends
- ❏ No

Do you use recreational drugs?

- ❏ Yes
- ❏ No

How often do you exercise?

- ❏ Daily
- ❏ Several times per week
- ❏ Once in a while
- ❏ Rarely
- ❏ Never

How is your diet?

- ❏ Healthy
- ❏ Sometimes healthy
- ❏ Fast food
- ❏ Other_____

Please list vitamins, supplements or herbs you are taking, and the reason for taking them:

_____
_____
_____

Please list your hobbies

_____
_____

Please describe your work activities:

_____
_____

What is your highest level of education?

- ❏ Some high school
- ❏ High school diploma or GED
- ❏ Some college
- ❏ Bachelor Degree
- ❏ Masters Degree
- ❏ Doctorate Degree, PhD, or equivalent
- ❏ Post Doctoral
- ❏ I prefer not to answer

Family Medical History

Please describe your family history. Please include parents and siblings.
Please list the approximate age at which they were diagnosed, if known.

Father:

- ❏ Unknown
- ❏ Diabetes
- ❏ High blood pressure
- ❏ Heart problems
- ❏ Stroke
- ❏ Cancer (what type) _____
- ❏ Other: _____
- ❏ None

*Age of diagnosis:*_____

Mother:

- ❏ Unknown
- ❏ Diabetes
- ❏ High blood pressure
- ❏ Heart problems
- ❏ Stroke
- ❏ Cancer (what type) _____
- ❏ Other: _____
- ❏ None

*Age of diagnosis:*_____

Siblings:

- ❏ Unknown
- ❏ Diabetes
- ❏ High blood pressure
- ❏ Heart problems
- ❏ Stroke
- ❏ Cancer (what type) _____
- ❏ Other: _____
- ❏ None

*Age of diagnosis:*_____

Review of systems

Please check all that apply

General:

- ❑ Unexplained weight loss
- ❑ Unexplained weight gain
- ❑ Change in sleeping patterns
- ❑ Change in activity levels
- ❑ Cancer
- ❑ None of these

Neurological:

- ❑ Anxiety
- ❑ Headaches
- ❑ Depression
- ❑ Meningitis
- ❑ Paralysis
- ❑ Seizure
- ❑ Tingling
- ❑ Stroke
- ❑ Memory loss
- ❑ Fainting spells
- ❑ Dizziness
- ❑ Head injuries
- ❑ Black outs or near black outs
- ❑ Change in sensation in any part of your body
- ❑ Localized weakness or numbness
- ❑ None of these

Eyes, ears, nose, throat:

- ❑ Hay fever
- ❑ Glaucoma
- ❑ Polyps
- ❑ Allergies
- ❑ Cataracts
- ❑ Goiter
- ❑ Hoarseness
- ❑ Gum problems
- ❑ Eye problems
- ❑ None of these
- ❑ Ear infections
- ❑ Glasses or contacts
- ❑ Hearing loss
- ❑ Ear discharge or pain
- ❑ Frequent nosebleeds
- ❑ Ringing in your ears
- ❑ Sinus infections
- ❑ Swollen glands

Cardiovascular:

- ❑ Angina
- ❑ Leg cramps
- ❑ Swelling
- ❑ Awakening at night short of breath
- ❑ Cardiac catheterization
- ❑ Cold hands or feet
- ❑ Congenital heart defects
- ❑ Dizziness when standing up quickly
- ❑ Heart attacks
- ❑ Heart failure
- ❑ High or low blood pressure
- ❑ Irregular heart beat
- ❑ Purple fingers or lips
- ❑ Leg pain that resolves with rest
- ❑ Heart palpitations
- ❑ Varicose veins
- ❑ Chest pains
- ❑ Murmurs
- ❑ None of these

Respiratory:

- ❑ Asthma
- ❑ Breathlessness when lying flat
- ❑ Prolonged cough
- ❑ Coughing up blood
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Wheezing
- ❑ Pleurisy
- ❑ None of these

Skin:

- ❑ Abscess
- ❑ Dandruff
- ❑ Acne
- ❑ Oily skin
- ❑ Boils
- ❑ Rashes
- ❑ Hives
- ❑ Dry skin
- ❑ Lumps
- ❑ Psoriasis
- ❑ Jaundice
- ❑ Athlete's foot
- ❑ Excessive body odor
- ❑ Excessive sweating
- ❑ Fungal infections
- ❑ Nail problems
- ❑ Moles Dash irregular
- ❑ Moles - changing / new
- ❑ None of these

Kidneys and urinary tract:

- ❑ Blood in urine
- ❑ Brown urine
- ❑ Dribbling after urination
- ❑ Painful urination
- ❑ Excessive thirst
- ❑ Frequent urination during the day
- ❑ Involuntary urination / incontinence
- ❑ Frequent urination at night
- ❑ Urine hesitancy
- ❑ Weak flow
- ❑ Frequent bladder infections
- ❑ Kidney infections
- ❑ Kidney stones
- ❑ None of these

Endocrine:

- ❑ Diabetes
- ❑ Sickle cell
- ❑ Abnormal body hair
- ❑ Changes in skin texture
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ History of "borderline" diabetes
- ❑ None of these

Musculoskeletal:

- ❑ Anemia
- ❑ Arthritis
- ❑ Low back pain
- ❑ Gout
- ❑ Bursitis
- ❑ Joint pain
- ❑ Neck pain
- ❑ Tendonitis
- ❑ Abnormal blood count
- ❑ Blood clots in legs / lungs
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Joint swelling
- ❑ Morning stiffness
- ❑ Muscle aches
- ❑ None of these

Gastrointestinal:

- ❑ Diarrhea
- ❑ Reflux
- ❑ Ulcers
- ❑ Hepatitis
- ❑ Abdominal pain
- ❑ Anal fissures
- ❑ Black tarry stool
- ❑ Vomiting blood
- ❑ Constipation
- ❑ Nausea
- ❑ Problems swallowing
- ❑ Hiatal hernia
- ❑ Bowel obstruction
- ❑ Liver disease
- ❑ Hemorrhoids
- ❑ Red blood after bowel movements
- ❑ Gallstones
- ❑ Vomiting
- ❑ Heartburn
- ❑ Indigestion
- ❑ None of these

Male and female:

- ❑ Painful sexual intercourse
- ❑ Loss of sexual interest
- ❑ Unprotected sex with multiple partners
- ❑ Groin itching
- ❑ Sexually transmitted disease
- ❑ None of these

Female only:

- ❑ N/A
- ❑ D & C
- ❑ Hot flashes
- ❑ Hernia
- ❑ Fibroids
- ❑ Abnormal bleeding between Cycles
- ❑ Abnormal pap smear
- ❑ Bleeding after intercourse
- ❑ Problems with pregnancy
- ❑ PMS
- ❑ Endometriosis
- ❑ Heavy bleeding during cycles
- ❑ Discharge from breasts
- ❑ Pelvic inflammatory disease
- ❑ Ovarian cyst
- ❑ Postmenopausal symptoms
- ❑ Vaginal discharge
- ❑ Vaginal dryness
- ❑ Vaginal warts
- ❑ None of these

Male only:

- ❑ N/A
- ❑ Hernia
- ❑ Sterility
- ❑ Blood in ejaculations
- ❑ Inability to complete intercourse
- ❑ Lump on testicle
- ❑ Penile discharge
- ❑ Difficulty getting or keeping erection
- ❑ Sores or warts on penis
- ❑ Prostate problems
- ❑ Testicular pain
- ❑ Testicular swelling
- ❑ None of these

Please list any condition not listed in this section

_____

* I affirm that all of the information on this form is true and accurate according to the best of my knowledge, and I consent to a chiropractic examination and treatment in accordance with this state's statutes.

Patient signature _____ Date _____

Parent/Guardian signature _____ Date _____