NEW PATIENT INTAKE FORM

ABOUT THE PATIENT

DATE_____/_____/_____

Name: ____ SS # ______-_____-______

LAST FIRST MI

Date of Birth: ____ / ____ / ____ Age: _____ Gender: ☐Male ☐Female

Address: ______________________ City: _____________ State: _______ Zip: ______________

Home Phone: (______) ______-______ Work Phone: (______) ______-______ Cell Phone: (______) ______-______

Email: ______________________ Would you like to receive our newsletter/promotions? ☐No ☐Yes

Occupation: __________________ Employer: ____________________ Type of Work: ___________

Emergency Contact: ____________ Emergency Contact Phone:(______) ______-______ Relation: _______________

Whom may we thank for referring you? ____________________________ How did you hear about us?__________________

ABOUT THE FAMILY

Marital Status: ☐Single ☐Dating ☐Married ☐Divorced ☐Widowed

Significant Others Name: ____________________ Phone: (______) ______-______

Children: ☐No ☐Yes How Many? _____________

Names: ________________________________ Ages: ________________

INSURANCE / PAYMENT INFORMATION

Reason for visit: ☐Injury ☐Sports Performance ☐Work Related ☐Auto Accident Related ☐Pregnancy ☐OTHER: ____________

Date of Incidence: _____ / _____ / _____ Claim # _______________ Policy # ____________

Do you plan on using your **insurance**? ☐No ☐Yes

Do you plan on paying with **cash**? ☐No ☐Yes If Yes, Please Sign ___________________

Do you have a: ☐HSA Account ☐Flex-Spending Account

PREVIOUS TREATMENT

Family Medical Doctor: ______________________________ Date of last visit: ______ / ______ / ______

Previous Chiropractic Care: ☐No ☐Yes Name: _______________ Date of last visit: ______ / ______ / ______

OTHER: ____

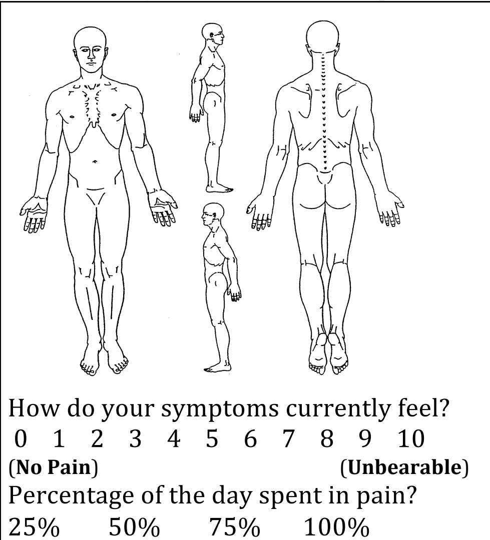
Previous Diagnosis: __________________________________ LAST XRAYS Taken: ______ / ______ / ______

REASON FOR VISIT

Current Health Concern: ______________________________ When did this condition start: ______ / ______ / _____

How did your symptoms begin: ____________________ How has your symptoms progressed: ☐Same ☐Better ☐Worse

Please Circle your area of main complaint



How do your symptoms currently feel?

0 1 2 3 4 5 6 7 8 9 10

(**No Pain**) (**Unbearable**)

Percentage of the day spent in pain?

25% 50% 75% 100%

How frequent is the condition?

☐Constant ☐Frequently ☐Intermittent ☐Occasionally

Describe your symptoms: ________________________________

☐Sharp ☐Dull ☐Aching ☐Burning ☐Numbness ☐Tingling ☐Throbbing

☐Stabbing ☐ OTHER _______________

Does anything relieve the problem? If yes, please list - ☐No ☐Yes__________________

Does anything make the problem worse? If yes, please list - ☐No ☐Yes_____________

Does this condition interfere with: ☐Work ☐Family ☐Daily Routine ☐Sleep ☐Sports

☐ OTHER: _______________

Have you experienced this problem before? ☐No ☐Yes

Please Explain: ________________________________

Have you sought treatment for this condition before? ☐No ☐Yes

Please Explain: ________________________________

What is your sense of urgency to relieve your pain and/or improve your performance? **0 1 2 3 4 5 6 7 8 9 10**

Not Interested *Very Interested*

PAST MEDICAL HISTORY

Please mark any of the following conditions that you have been diagnosed with or experienced.

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies List:________
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Lump(s)
☐ Blood Pressure High Low
☐ Cancer
☐ Circulatory Problems List:__________
☐ Cholesterol High
☐ Congenital Disease List:__________
☐ Depression
☐ Diabetes Type I Type II
☐ Diarrhea
☐ Digestive Problems
☐ Dizziness
☐ Eating Disorder
☐ Epilepsy
☐ Excessive Thirst
☐ Fainting
☐ Fatigue
☐ Fever
☐ Fractures
☐ Headaches
☐ Heartburn
☐ Heart Problems
☐ Hernia
☐ Herniated Disc List:________
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Miscarriage
☐ Mononucleosis
☐ Nausea
☐ Night Sweats
☐ Numbness
☐ Osteoporosis
☐ Pacemaker
☐ Pinched Nerve
☐ Pneumonia
☐ Prostate Problems Explain:_________
☐ Ringing in the ears
☐ Sleep Problems Too Little Too Much
☐ Shortness of breath
☐ Stroke
☐ Thyroid Problems Explain:________
☐ Tuberculosis
☐ Tumor(s) List:______
☐ Unexplained Weight Loss
☐ Visual Problems
☐ Vomiting

☐ OTHER:
____
____
____

CURRENT MEDICATIONS

Are you taking any medication or drugs? ☐No ☐Yes PleaseList:______________________________

EXERCISE	WORK ACTIVITY	HABITS
☐None	☐Sitting	☐Smoking Packs / Day ____________
☐Moderate	☐Standing	☐Alcohol Drinks / Week ____________
☐Daily	☐Light Labor	☐Caffeine Cups / Day ____________
☐Heavy	☐Heavy Labor	☐Stress - ☐Low /☐High Reason:____________
Type:____________	☐Other:____________	DIET:
Sport you play: ________		
Position:____________ Level:____________		SUPPLEMENTS:____________

AWARENESS OF RAK CHIROPRACTIC

Did you know that the ADJUSTMENT directly influences your Nervous System? ☐ No ☐ Yes
Did you also know that your Nervous System controls every function in YOUR Body? ☐ No ☐ Yes
Are you aware that Dr. Katie is a certified pediatric, pre and postnatal chiropractor? ☐ No ☐ Yes
Also, did you know she is Graston Technique Certified? ☐ No ☐ Yes
Did you know that Dr. Katie played college basketball? ☐ No ☐ Yes
Did you know that infants should be adjusted from the moment they are born? ☐ No ☐ Yes Explain why:________________

Did you know that one of the original Dr. Mayo brothers took his wife to the founder of Chiropractic, Dr. BJ Palmer for Chiropractic Treatment?
☐No☐ Yes

Are you aware that Dr. Ryley is certified in Active Release Technique, Graston Technique and Kinesio Taping? ☐ No ☐ Yes
Did you know that Dr. Ryley was born and raised in Canada? ☐ No ☐ Yes
Did you also know he attended 2 NHL Tryout Camps? ☐ No ☐ Yes

Did you know the specialized treatments RAK CHIROPRACTIC provides, when combined with stretching education and therapeutic exercises are proven to reduce symptoms, restore proper biomechanics (through the CHIROPRACTIC ADJUSTMENT), improve flexibility and decrease the chance of recurrence, while improving sport performance? ☐ No ☐ Yes

Patient Name:______________________

Patient (or Guardian) Signature:______________________ Date: ______ / ______ / ______