NEW PATIENT INTAKE FORM

ABOUT THE PATIENT DATE_____/_____/_____

Name: ______________________________ SS # ______-_____-______

LAST FIRST MI

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

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

Phone: (______) ______-______ Work Phone: (______) ______-______

Email: ______________________

Occupation: ________________ Employer: ________________ Type of Work: __________

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

Whom may we thank for referring you? ______________________

How did you hear about us? ☐Google ☐Facebook ☐Family/Friend ☐Other:______________________

ABOUT THE FAMILY

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

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

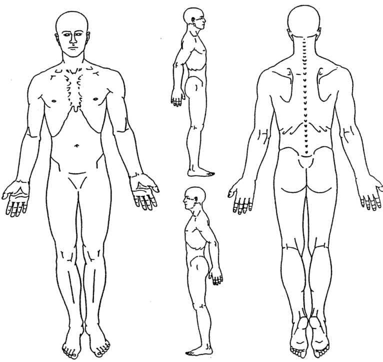
Children: ☐No ☐Yes How Many? ____________ Ages: ________________

REASON FOR VISIT

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

How did your symptoms begin: ______________________

Please CIRLCE your area(s) 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 has your symptoms progressed: ☐Same ☐Better ☐Worse

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__________

Have you experienced this problem before? ☐No ☐Yes

Please Explain: ______________________

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

Please Explain: ______________________

Does your condition interfere with any of the following:

☐Driving ☐Computer Use ☐Lifting ☐Bending ☐Cooking

☐Cleaning ☐Yardwork ☐Watching Kids ☐Sports ☐Work

☐Exercise ☐Sleep ☐Selfcare ☐Social Life ☐Daily Routine

☐OTHER ______________

GOALS

We want to make sure you get the absolute best chiropractic care and the best service therefore we want to know **your TOP functional goals** that you have with your care with us:

☐Better Sleep ☐Being comfortable traveling / driving

☐Healthy Pregnancy / Delivery ☐Exercise Again ☐Play with kids/grandkids normally

☐Wake up with less pain ☐Back to work ASAP ☐ Better mood/energy

☐Better for upcoming race/event ☐Sit/Stand for longer periods of time ☐Off or less medication

☐OTHER ______________

PAST MEDICAL HISTORY

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

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies List:________
☐ Arthritis
☐ Bleeding Disorder
☐ Breast Lump(s)
☐ Blood Pressure High Low
☐ Cancer
☐ Circulatory Problems List:__________
☐ Cholesterol High
☐ Congenital Disease List:__________

☐ Diabetes Type I Type II
☐ Heart Problems
☐ Herniated Disc List:________
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Osteoporosis
☐ Pacemaker
☐ Prostate Problems Explain:_________
☐ 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:____

LIFESTYLE

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:	

SUPPLEMENTS:______________________________

At RAK Chiropractic we want to offer THE best possible care to our patients.

We have had great success in helping our patients with many other conditions.

Please mark any/all that apply to you so that RAK can help you achieve to be your best.

Do you currently / Have you ever experienced any of the following:

☐Neck Pain
☐Migraines / Headaches
☐Depression / Anxiety
☐Chronic Sinus Infections
☐Constantly Sick
☐Constipation
☐Genital Pain
☐Ringing Ears
☐Brain Fog
☐Stomach Pain (Gas/Bloat)
☐Back Pain
☐Allergies
☐Chronic Fatigue
☐Tingly Hands/Feet
☐Leg Pain
☐Dizziness
☐Muscle Cramps
☐Heartburn
☐Infertility
☐Sciatica
☐Menstrual Problems (Headaches/Irregularity)
☐Other: ______________________________

____
Patient Name

____
Patient Signature

______ / ______ / ______
Date