GRAND TRAVERSE FAMILY CHIROPRACTIC
PAIN RELIEF | WELLNESS

New Patient Intake Form

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Last Name _____ **First Name** _____ **M.I** ____ **Preferred Name** (if any) _____ **Birthdate (MM/DD/YY)** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Cell Phone ○ (fill circle for text reminders) _____ **Home Phone** _____ **Email** ○ (fill circle for email reminders) _____

Social Security Number _____ **Occupation** _____ **Employer** _____

Spouse _____ **Spouses Contact Information** _____ **Number of Children** _____

Emergency Contact _____ **Emergency Contact's Phone** _____ **Whom may we thank for referring you?** _____

Primary Complaint The primary symptom that prompted me to seek care today is: _____

Onset Date _____ **Was this the result of** ○ accident or injury ○ work ○ auto ○ other _____

Is this progressively getting worse? ○ Yes ○ No **Have you had this or a similar condition in the past?** ○ Yes ○ No

Intensity (How extreme are your current symptoms?) **0** ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ **10**
Mild **Moderate** **Severe**

Quality of symptoms (What does it feel like?) ○ Ache ○ Burn ○ Throb ○ Numb ○ Sharp ○ Shooting ○ Stabbing ○ Tightness ○ Tingling
○ Radiating (To what areas does the pain radiate, shoot or travel) _____

Frequency of symptoms (percentage of day, days/week, times/month) _____

Prior interventions (What have you done to relieve the symptoms?) ○ Chiropractic ○ Massage ○ Acupuncture ○ Physical Therapy ○ Ice ○ Heat
○ Prescription medication ○ Over-the-counter drugs ○ Homeopathic remedies ○ Surgery ○ Other _____

What have you found that makes this condition better/worse? _____

Secondary Complaint The secondary symptom that prompted me to seek care today is: _____

Onset Date _____ **Was this the result of** ○ accident or injury ○ work ○ auto ○ other _____

Is this progressively getting worse? ○ Yes ○ No **Have you had this or a similar condition in the past?** ○ Yes ○ No

Intensity (How extreme are your current symptoms?) **0** ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ **10**
Mild **Moderate** **Severe**

Quality of symptoms (What does it feel like?) ○ Ache ○ Burn ○ Throb ○ Numb ○ Sharp ○ Shooting ○ Stabbing ○ Tightness ○ Tingling
○ Radiating (To what areas does the pain radiate, shoot or travel) _____

Frequency of symptoms (percentage of day, days/week, times/month) _____

Prior interventions (What have you done to relieve the symptoms?) ○ Chiropractic ○ Massage ○ Acupuncture ○ Physical Therapy ○ Ice ○ Heat
○ Prescription medication ○ Over-the-counter drugs ○ Homeopathic remedies ○ Surgery ○ Other _____

What have you found that makes this condition better/worse? _____

Additional Complaint The additional symptom that prompted me to seek care today is: _____

Onset Date _____ **Was this the result of** ○ accident or injury ○ work ○ auto ○ other _____

Is this progressively getting worse? ○ Yes ○ No **Have you had this or a similar condition in the past?** ○ Yes ○ No

Intensity (How extreme are your current symptoms?) **0** ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ - ○ **10**

Mild **Moderate** **Severe**

Quality of symptoms (What does it feel like?) ○ Ache ○ Burn ○ Throb ○ Numb ○ Sharp ○ Shooting ○ Stabbing ○ Tightness ○ Tingling

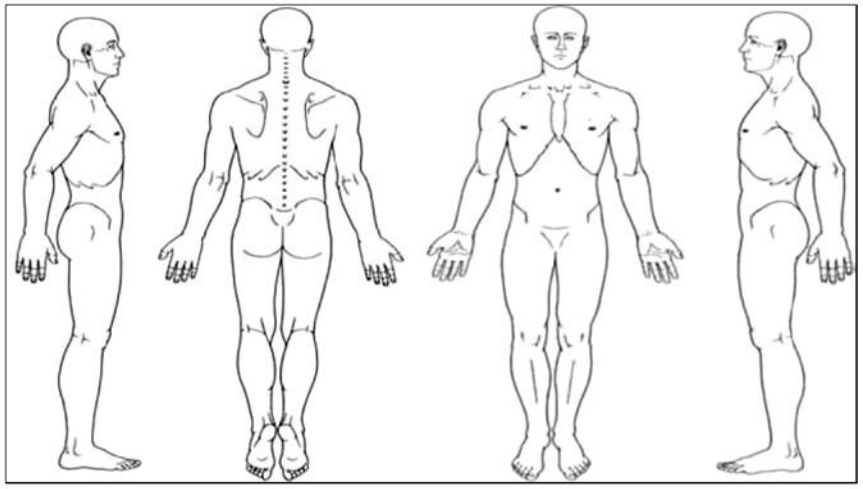
○ Radiating (To what areas does the pain radiate, shoot or travel) _____

Frequency of symptoms (percentage of day, days/week, times/month) _____

Prior interventions (What have you done to relieve the symptoms?) ○ Chiropractic ○ Massage ○ Acupuncture ○ Physical Therapy ○ Ice ○ Heat

○ Prescription medication ○ Over-the-counter drugs ○ Homeopathic remedies ○ Surgery ○ Other _____

What have you found that makes this condition better/worse? _____



Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing on the diagrams.

A=Ache
B=Burn
TH=Throb
N=Numb
SHAR=Sharp
SHO=Shooting
TIG=Tightness
TIN=Tingling

Patient Health History

Have you ever had Chiropractic care before? ○ Yes ○ No Name of Doctor: _____ Date: _____

Was there anything you liked/disliked about your previous care? _____

Last time you had spinal X-rays: _____ Were there any significant findings?_____

Medications/Supplements you now take: _____

Please fill in any previous or current medical conditions: ○ Allergies ○ Arteriosclerosis ○ Arthritis ○ Asthma ○ Back Pain ○ Cancer

○ Constipation/Digestion Problems ○ Diabetes ○ Dizziness ○ Headaches ○ Heart Disease ○ High Blood Pressure ○ Multiple Sclerosis

○ Stroke ○ Thyroid Conditions ○ Other_____

Please list any significant past injuries/accidents by date: _____

_____

Please list any past surgeries/treatments/hospitalizations by date: _____

_____

Please list any other important information, goals for care, and notes for the doctor here: _____

_____

_____ _____

Signature **Date**