North St. Paul Chiropractic

INTAKE FORM

PERSONAL INFORMATION

Today's Date _____

Name _____

First MI Last

Preferred First Name (nickname) _____

Gender □ male □ female Date of Birth ____/____/____

Home Address _____

City _____ State ____ Zip_____

Email Address_____

Employer _____

Employer Address _____

_____

Occupation/Position _____

Spouse's Name _____

How were you referred to this office?

Referred by _____

□ sign □ internet □ website □ insurance □ phone book

Other _____

PHONE NUMBERS

Home _____

Work _____ Ext _____

Cell _____

In case of emergency, contact _____

Relationship to you _____

Phone Number _____

ACCIDENT INFORMATION

Is your current condition due to a recent accident?

□ yes □ no

Type of accident:

□ auto □ work □ home □ other _____

Date of accident _____

IF YES IMMEDITATELY INFORM THE FRONT DESK

Insurance carrier name:

_____

REASON FOR MY VISIT TODAY

Reason for visit today: _____

_____

When/how did it start? _____

The condition is: □ getting worse □ staying the same

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it wake you at night or interfere with sleep? □ yes □ no

Have you ever had a condition like this or similar? □ yes □ no

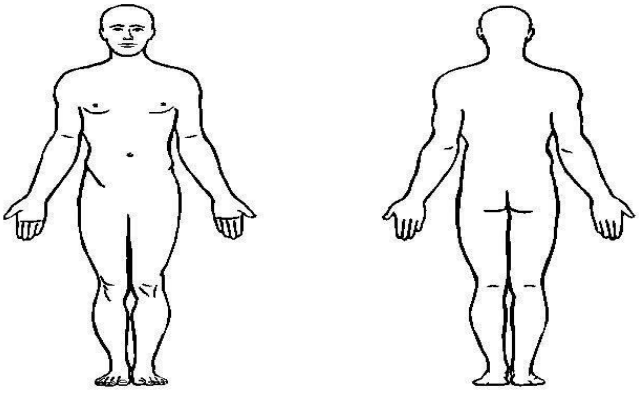
If yes, when _____

Does it interfere with your: □ work □ sleep □ daily routine

Activities that are painful: □ sitting □ standing □ bending

□ walking □ laying down

Please describe any additional information or concerns you would like the doctor to know _____



HEALTH HABITS

Do you exercise regularly? □ yes □ no

Do you: □ smoke – packs/day _____

□ drink alcohol – drinks/week _____

□ drink coffee, tea, or soda/caffeine – cups/day _____

□ eat processed food or fast food

Your general stress level: □ none □ light □ moderate □ high

INTAKE FORM

HEALTH HISTORY

Have you ever received care from a Chiropractor? □ yes □ no If yes, when was your last visit? _____

Where? _____

Additional health concerns you may have: _____

_____

SYSTEMS REVIEW: From the following list, please check any symptom or condition that applies to you.

SKIN
□ Rashes, psoriasis, dermatitis
□ History of skin cancer

EYES
□ Cataracts
□ Glaucoma

EARS / NOSE / THROAT
□ Loss of hearing
□ Ringing in the ears
□ Frequent earaches
□ Attacks of vertigo
□ Frequent sinus infections
□ Frequent sore throat
□ Loud snoring / sleep apnea
□ Difficulty in swallowing
□ Frequent headaches
□ Nose bleeds
□ Allergies

RESPIRATORY
□ Asthma or wheezing
□ Recent bronchitis or chest cold
□ Cough lasting more than 2 months
□ Coughing up blood
□ Shortness of breath

HEART & CIRCULATION
□ Heart attack
□ Hypertension (high blood pressure)
□ Heart murmur
□ Chest pain with activity (angina)
□ Heart failure / fluid on lungs
□ Palpitations, racing or pounding

(HEART CONT.)
□ Stroke
□ TIAs or "mini strokes"
□ Aneurysm of any blood vessel
□ Frequent ankle swelling

STOMACH / INTESTINES
□ Stomach or peptic ulcer
□ Frequent heartburn or indigestion
□ Gallbladder attacks / removed
□ Frequent diarrhea
□ Chronic constipation
□ Bright blood from rectum or bowels
□ Dark, tarry stools
□ Liver disease or jaundice

ENDOCRINE / METABOLISM
□ Thyroid disorder
□ Recent weight gain or loss (> 10 lbs)
□ Diabetes

KIDNEY / URINARY TRACT
□ Kidney disease or failure
□ Kidney stones or infection
□ Pain or burning with urination
□ Trouble starting flow,
□ Dribbling or incontinence
□ Bladder infections
□ Blood in urine
□ Prostate disease

MUSCLES / BONES / JOINTS
□ Arthritis or other joint disease
□ Chronic back trouble
□Other Joint/Bone/Muscle Disease:
_____

NERVOUS SYSTEM
□ Migraine headaches
□ Epilepsy or seizures
Date of last seizure: _____
□ Depression
□ Other nervous system disorder
Specify: _____

BLOOD
□ Bleeding and bruising
□ Previous blood transfusion
□ History of hepatitis

REPRODUCTIVE (Women only)
Are you or might you be pregnant?
□ yes □ no

SURGICAL HISTORY _____

_____

_____

FAMILY HISTORY
Check any of the following diseases your family has experienced:
□ Diabetes
□ Cancer
□ Heart disease
□ Stroke
□ Arthritis
List any other illness that "runs in your family": _____

_____

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS I CURRENTLY TAKE DAILY

□ Cholesterol medication □ Blood pressure medication □ Antacids / acid reflux meds

□ Advil / ibuprofen □ Stimulants □ Blood thinners

□ Tylenol / acetaminophen □ Tranquilizers □ _____

Vitamins & Supplements I take daily: _____

_____

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: _____ Date: _____

Physician Review: _____

North St. Paul Chiropractic
2516 East Seventh Avenue, North St. Paul, MN 55109 * Phone: 651-770-3805 * Fax: 651-747-8737 * www.northstpaulchiro.com