DESERT SPRINGS CHIROPRACTIC NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:( )_____ Work: ( )_____ Cell: ( )_____

Email Address:_____ Sex: ◯M ◯F

Social Security Number:_____ Birth Date:_____ Age:_____

Occupation:_____

Employer Name and Address:_____

Marital Status: _____ Spouse's Name: _____

HSA Flex

Insurance: Primary_____ Secondary_____ Do you have one of the following? Amt $_____

Have you seen a Chiropractor before? ◯Yes ◯No If yes, when?_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

☐ Headaches	☐ Pins and Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck Stiff	☐ Cold hands	☐ Cold feet
☐ Cold Sweats	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Mood Swings	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
	☐ Menstrual Pain	☐ Menstrual irregularity	☐ Ulcer

Main Complaint:_____

List any medications you are taking: _____

Have you been in a car accident recently? ◯Yes ◯No If so, when? _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Office Use only CT#: _____

Functional Rating Index

Regarding your MAIN COMPLAINT

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities.

For each item below, please select the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on shorts trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25 % of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____

PRINTED

_____ _____

Signature **Date**