

NUVITA CHIROPRACTIC NEW PATIENT INTAKE

Name: _____ Today's Date: _____

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

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

Email Address: _____ Male: _____ Female: _____

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

Occupation: _____

Employer Name and Address: _____

Single: _____ Married: _____ Spouse's Name: _____

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.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Heartburn |
| | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers |

Main Complaint: _____

Do you smoke? Yes / No If yes, how many years/packs per day? _____

List any medications you are taking: _____

Do you have any medically diagnosed conditions? _____

Does anyone in your family have any medically diagnosed conditions? (If yes, whom)? _____

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

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: _____

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

6. Recreation

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

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

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

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

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

9. Walking

No pain any distance Increased pain after 1 mile Increased pain after 1/2 mile Increased pain after 1/4 mile Increased pain with all walking

5. Work

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

10. Standing

No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after 1/2 hour Increased pain with any standing

Name _____

PRINTED

Signature _____

Date _____

Doctor's Signature _____

Date Forms Reviewed _____