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.

☐ Headaches	☐ Pins and needles in legs	☐ Infertility	☐ Dizziness
☐ Neck pain/stiffness	☐ Pins and needles in arms	☐ Hip pain	☐ Loss of Balance
☐ Mid back pain	☐ Finger numbness	☐ Shoulder pain	☐ Nervousness
☐ Low back pain	☐ Toe numbness	☐ Loss of taste	☐ Stomach upset
☐ Ringing in ears	☐ Allergies	☐ Irritability	☐ Constipation
☐ Fatigue	☐ Asthma	☐ Cold hands	☐ Ulcers
☐ Sleeping problems	☐ Hot flashes	☐ Cold feet	☐ Heartburn
☐ Cold Sweats	☐ Menstrual pain	☐ Problem urinating	☐ Skin issues
☐ Mood Swings	☐ Irregular cycles	☐ Blood pressure issues	☐ Fainting

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

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 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

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**

____ **Doctor's Signature**

_____ - _____ - _____ **Date Forms Reviewed**