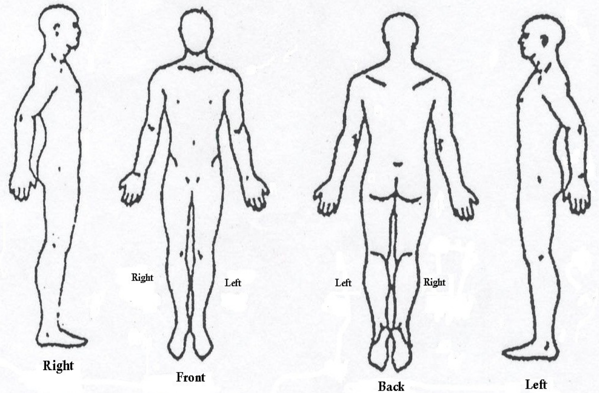
Patient Intake Form

General Information



First Name: ______________________________ **MI:** ________
Last Name: ____
Called Name: ____

Address: ____
City: ____
State: __________ **Zip Code:** ____________________

Birthdate: _____________/_______________/___________
Sex: **Male** **Female**

Home Phone: (________)________________________________
Cell Phone: (________)________________________________
Work Phone: (________)________________________________
E-Mail: ____
Occupation: ____
Marital Status: ____
Children: **Yes** **No**

Have you visited our website? **Yes** **No**
Have you had Chiropractic care before? **Yes** **No** **If yes, when and with whom:** ___________________________
Who can we thank for referring you to Flynn Chiropractic? ____

What date did your symptoms begin? _______________/____________________/___________________

Briefly describe your symptoms:
____
____

How did your symptoms start:
____
____

Average pain intensity:

Last 24 hours:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain
Past week:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

How often do you experience your pain?
Constantly Frequently Occasionally Intermittently

How much have your symptoms interfered with your usual daily activities?
Not at all A little bit Moderately Quite a bit Extremely

How is your condition changing, since care began at *this* facility?
N/A—Initial visit Much worse Worse A little worse No change A little better Better Much better

In general, would you say your overall health right now is:
Excellent Very Good Good Fair Poor

Insured Information

Name of Primary Policy Holder: ___________________________________ **Relation to Patient:** _________________________
Insured Employer: ____ **Date of birth of Insured:** _______/_______/______

I hereby authorize payment directly to Flynn Chiropractic of all insurance benefits otherwise payable to me for the services rendered. I understand that I am finically responsible for all charges, whether or not paid by insurance, and for all services rendered on behalf of my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ____ **Date:** _____________________________________

Do you suffer from any condition other than for which you are now consulting us? **Yes** **No**
If yes, please explain: ____
____

List any past conditions you may have had: ____

HABITS

- ☐ Smoking Packs/Day: _____
- ☐ Alcohol Cups/Day: _____
- ☐ Coffee Cups/Day: _____
- ☐ Soft Drinks Cans/Day: _____
- ☐ Water Cups/Day: _____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily

Type: ________________________
____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	☐	☐	☐	☐ ____________
Father	☐	☐	☐	☐ ____________
Brother(s)	☐	☐	☐	☐ ____________
Sister(s)	☐	☐	☐	☐ ____________

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc.? **Yes** **No**
If yes, which ones: ____
____

Have you taken any medications in the past? **Yes** **No** **If yes, which ones:** ______________________________
____

Do you have allergies? **Yes** **No** **If yes, please explain:** ____
Have you ever had any surgeries? **Yes** **No** (If yes, please enter approximate date of surgery)

__________ Back Operation __________ Hernia __________ Gall Bladder __________ Female Organs

__________ Thyroid __________ Stomach __________ Heart __________ Other ____________

Have you ever had X-rays taken? **Yes** **No** **When:** __________________ **By Whom:** __________________
For what ailments were these X-rays taken? ____

Operations and Procedures

Please check the box for each current or past symptom listed

GENERAL SYMTOMS

- ☐ Bronchitis
- ☐ Chills (Constant)
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Wheezing
- ☐ Numbness or pain in arms/legs/hands/feet

GASTRO-INTESTINAL

- ☐ Belching or gas
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Heart burn
- ☐ Bloody stools
- ☐ Acid reflux
- ☐ Irritable bowel

EYE/EAR NOSE/THROAT

- ☐ Asthma
- ☐ Deafness
- ☐ Eacache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Thyroid problems
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Pain in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Tonsillitis

RESPIRATORY

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting blood
- ☐ Spitting phlegm

MUSCLES AND JOINTS

- ☐ Backache
- ☐ Foot trouble
- ☐ Hernia
- ☐ Pain between shoulders
- ☐ Painful tail bone
- ☐ Stiff neck
- ☐ Spinal curvature
- ☐ Swollen joints
- ☐ Tremors
- ☐ Twitching

OPERATIONS AND PROCEDURES CONT'D

CARDIO-VASCULAR	*GENITO-URINARY*	*SKIN or ALLERGIES*	*FOR FEMALES ONLY*
☐ High blood pressure	☐ Bed wetting	☐ Bruising easily	☐ Cramps
☐ Low blood pressure	☐ Blood in urine	☐ Dryness	☐ Hot flashes
☐ Chest pain	☐ Frequent urination	☐ Eczema	☐ Irregular cycle
☐ Heart trouble	☐ Inability to control urine	☐ Hives or allergy	☐ Painful periods
☐ Poor circulation	☐ Kidney infection	☐ Itching	☐ Pregnant now?
☐ Stroke	☐ Kidney stones	☐ Sensitive skin	__________ date of last pap
☐ Irregular heartbeat	☐ Painful urination	☐ Skin eruptions	__________ date of last menstrual period
☐ Varicose veins	☐ Prostate trouble		
☐ Swelling ankles			

Do you have or have you had any of the following diseases?

☐ Appendicitis	☐ Anemia	☐ Heart disease	☐ Arthritis	☐ Pneumonia	☐ Measles	☐ Epilepsy
☐ Goiter	☐ Rheumatic fever	☐ Mumps	☐ Influenza	☐ Mental disorder	☐ Polio	☐ Chicken pox
☐ Pleurisy	☐ Lumbago	☐ Tuberculosis	☐ Diabetes	☐ Alcoholism	☐ Eczema	☐ Whooping cough
☐ Cancer	☐ Venereal	☐ HIV positive	☐ STD	☐ Emphysema	☐ Disc injury	☐ Other

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic health care, and I give authorization for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain property of this office, being on file where they may be viewed.

Patient/Guardian Signature: ____ **Date:** ______________________________