Proactive Chiropractic & Wellness

2434 Wall Street / Suite A
Conyers, GA 30013
Phone: (770) 679-5515
Fax: (770) 648-6682

Patient Intake Form

Date _____

First Name _____
Last Name _____
DOB _____
Sex ◯ Male ◯ Female
SSN _____
Address _____
City _____
State _____
Zip Code _____

Phone 1 _____
◯ Home ◯ Mobile ◯ Work ◯ Other
Phone 2 _____
◯ Home ◯ Mobile ◯ Work ◯ Other
Fax _____
Email _____
Employer _____
Employer Phone _____
Occupation _____

Job Status
◯ Not Employed ◯ Employed
◯ Part-Time Student ◯ Retired
◯ Full-Time Student

Marital Status
◯ Single ◯ Married ◯ Other

Receive Appointment Reminders
◯ Declined ◯ Voice ◯ Text ◯ Email

Height ___ ' ___ "
Weight _____ lbs

Reason For Visit: ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury ◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other _____

Referred By: ◯ Provider ◯ Friend ◯ Family ◯ Other _____
Referred By Name _____

How Heard of Us: ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website ◯ Advertisement ◯ Other _____

Demographics

Preferred Language: _____ **Dominance:** ◯ Right ◯ Left ◯ Ambidextrous

Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or Other Specific Islander ◯ Other _____

Ethnicity: ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Unknown ◯ Other _____

Insurance Information

Primary Insurance:

Insured First Name _____
Insured Last Name _____
DOB _____
Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay _____
Co-Ins % _____
Deductible _____ Applied _____
$/Year _____ Visits/Year _____ Therapy Visits/Year _____
PCP Referral Required ◯ Yes ◯ No
Policy Effective Date _____
Cal Yr / Other _____
Other _____

Secondary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

$/Year _____ Visits/Year _____ Therapy Visits/Year _____

PCP Referral Required ◯ Yes ◯ No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Emergency Contact Information

First Name _____ Relationship _____

Last Name _____ Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Chronic Fatigue	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Asthma	☐ Emphysema	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Epilepsy	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Breast Lump	☐ Fibromyalgia	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Bronchitis	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Cancer	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Chemical Dependency	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Disorder	☐ Venereal Disease
☐ Chicken Pox	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries:

Traumas:

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Does the pain travel anywhere else? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? _____

Frequency: _____ times per ◯ Day ◯ Week ◯ Month ◯ Year

Duration: Lasting _____ ◯ Minutes ◯ Hours

Onset: Have had symptoms over the past _____ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Slight ◯ Moderate ◯ Severe

Is your condition: ◯ Same ◯ Better ◯ Worse

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Aggravating Factors: What makes the problem worse? ☐ nothing ☐ most movements ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ eating ☐ excercise ☐ going down stairs ☐ going from lying to sitting ☐ going from lying to standing ☐ going from sitting to standing ☐ heat ☐ housework ☐ ice ☐ jogging ☐ lifting ☐ lying down ☐ massage ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching ☐ taking a deep breath ☐ turning ☐ twisting ☐ walking ☐ working

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching ☐ walking ☐ wraps

What daily activities are affected due to the problem? ☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs ☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ going from laying down to sitting ☐ going from sitting to standing ☐ grooming ☐ house work ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting ☐ transferring ☐ using technology ☐ using phone ☐ walking ☐ watching tv ☐ working ☐ yard work

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic

☐ Low (Time of Day) _____ ☐ High (Time of Day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ◯ None ◯ Low ◯ Moderate ◯ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? _____

Daily Habits

Do you smoke? ◯ Never smoked ◯ Unknown if ever smoked ◯ Unknown if currently smokes

◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ no ◯ light ◯ moderate ◯ heavy

Review of Systems

Musculoskeletal: Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm ☐ Persistent Coughing

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps

☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing

☐ Other _____

Eyes: Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma

☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

Ears: Please check all that apply ☐ None

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing

☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds

☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

Throat/Mouth: Please check all that apply ☐ None

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness

☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling

☐ Thrush ☐ Tooth pain ☐ Other _____

Urinary: Please check all that apply ☐ None

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary track infections

☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)

☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

Gastrointestinal: Please check all that apply ☐ None

☐ Change in appetite ☐ Change in bowl habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea

☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Endocrine: Please check all that apply ☐ None

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst

☐ Frequent urination ☐ Heat intolerence ☐ Sweating

Vascular/Hematologic: Please check all that apply ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply ☐ None

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness

☐ Worry/anxiety ☐ Other _____

Psychiatric: Please check all that apply ☐ None

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

Female:

Are you pregnant? ◯ Yes ◯ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply ☐ None

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

Male: Please check all that apply ☐ None

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date _____

Print Name of Patient, Parent, Guardian or Personal Representative