Connected Chiropractic
221 NC Hwy 42 E
Clayton, NC 27527
(919)550-1099

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Personal Information

*First Name: _____
Middle Name: _____
*Last Name: _____
Gender: ○ Female ○ Male
Date of Birth: _____
Social Security #: ___ ___ ____
Height: ▼ Feet ▼ Inches
Weight: _____
Marital Status: ▼
Spouse's Name: _____
Number of Children: ▼

Emergency Contact: _____
Relationship: _____
Phone: _____

Contact Information

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

Home Phone: _____
Cell Phone: _____
Work Phone: _____

Country: United States ▼
Address Line 1: _____
Address Line 2: _____
City: _____
State/Province/Region: ▼
Zip/Postal Code: _____

How did you find out about our office?

Referring Physician: _____
Referring Patient: _____
Referred by: ▼

Did you hear about our office from an advertisement?

No Yes

If Yes, Where:

Did you hear about our office from a phone or professional directory?

No Yes

If Yes, Where:

Employment Information

Regular Work Status:

Employer Name:

Employer Address:

Employer City:

Employer State:

Employer Zip:

Occupation:

Supervisor Name:

Supervisor Phone/Extension:

Physical Work Duties:

What is the purpose of your visit?

Wellness Complaint Injury Other

Current Symptoms

Where did the injury occur?

Automobile Work 3rd Party Premises Other

Date of Injury:

Please Describe how the injury, pain, or discomfort originated:

Please describe your pain/discomfort:

Select frequency you experience pain from this condition:

Always Hourly Daily Occasionally

Does this condition interfere with any of your daily activities or routines?

No Yes

Has this condition affected your quality of sleep or ability to sleep?

No Yes

Has this condition affected your appetite?

No Yes

If Yes, Explain:

Have you missed any work due to this injury?

No Yes

If yes:
Select unable to work from date:
Select day you have or will return to work:

Have you reduced or limited your work hours because of this condition?

No Yes

If Yes, Explain:

Is the pain/discomfort worse at certain times of the day?

No Yes

If Yes, Explain:

Does the weather affect your pain/discomfort?

No Yes

If Yes, Explain:

List anything that aggravates your condition:

List anything that relieves or improves your condition:

Have you received professional treatment for this condition?

No Yes

If Yes, Explain:

Have you had X-rays taken for this condition?

No Yes

If Yes, Where?

Pain level Rating - Scale 1 to 10 (Where 1 is least pain and 10 is maximum pain)

At its best: ▼ At its Worst: ▼

Current Level: ▼

Have you ever had this same condition?

No Yes

If Yes, When?:

List other practitioners seen for this injury/condition:

Personal Health History

Family/Primary Physician

Date of Last Physical Exam:

Name of Family Physician or Physician Seen:

Physician Phone:

Physician City:

Physician State: ▼

Physician Zip:

Please list any health conditions that you have been treated for in the last year:
(condition, cause, current/resolved)

Separate details w ith "," comma as show n above.

Have you had previous chiropractic care?

No Yes

Condition(s) treated:

Date of last chiropractic visit:

Are you pregnant, or have you had any signs of pregnancy? (Female Only)

No Yes

Are you planning to get pregnant in the next 12 months? (Female Only)

No Yes

List current medications:
(name, amounts, frequency, length of use, reason for use)

Separate details with "," comma as shown above.

List current vitamins, minerals, supplements, or herbs:
(name, amounts, frequency, length of use, reason for use)

Separate details with "," comma as shown above.

Personal Incident History:

Broken Bones?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Had Major Sprains/Strains?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Been Hospitalized?

No Yes

Briefly Explain: _____

Had Surgery?

No Yes

Briefly Explain: _____

Been In Auto Accident?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Been Struck Unconscious?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Been Diagnosed with an Eating Disorder?

No Yes

Briefly Explain: _____

Had a Stroke?

No Yes

Briefly Explain: _____

Family Health History

Please list diagnosed health conditions and untimely deaths.(condition, relationship to you)
(Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)

Separate details w ith "," comma as show n above.

(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Social History & Life Choices:

Alcohol
Daily Weekly Occasionally Never

Caffeine Drinks & Products
Daily Weekly Occasionally Never

Diet Food Products
Daily Weekly Occasionally Never

Drugs
Daily Weekly Occasionally Never

Energy Products or Over-the-Counter Stimulants
Daily Weekly Occasionally Never

Exercise
Daily Weekly Occasionally Never

Fresh & Homemade Foods
Daily Weekly Occasionally Never

Preprocessed, Packaged, & Restaurant Food
Daily Weekly Occasionally Never

Soft Drinks
Daily Weekly Occasionally Never

Tobacco
Daily Weekly Occasionally Never

Water
Daily Weekly Occasionally Never

Reason for this Visit

Describe the reason for this visit

Please briefly describe, including the impact it has had on your life.

If you're only here for chiropractic w ellness services please skip this section.

Wellness Sports Auto Fall Home Injury Job Chronic Discomfort Other

Briefly Explain:

_____

When did this concern begin?

_____

Has this concern:

○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain:

_____

Has this concern occured before?

○ Yes ○ No

Briefly Explain:

_____

Have you seen other doctors for this concern?

○ Yes ○ No

Doctor's Name:

_____

Type of Treatment:

_____

Results: ○ Good ○ Bad ○ Indifferent

For Women Only

COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A WOMAN OVER 16 YEARS OF AGE.

Are you pregnant?

○ No ○ Yes

Are you nursing?

○ No ○ Yes

Are you taking birth control?

○ No ○ Yes

Do you experience painful periods?

○ No ○ Yes

Do you have irregular cycles?

No Yes

Do you have breast implants?

No Yes

Do you perform a regular self breast examination?

No Yes

Do you take hormone replacement therapy (HRT)?

No Yes

Do you take oral contraceptives?

No Yes

Estimate the date of your most recent PAP/pelvic exam:

_____

Date of last mammogram?

_____

Date of Last Menstrual Period?

_____

Health Problems & Concerns:

Please select all that you have had or currently have.

- Allergies
- Alcoholism
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Autoimmune Disease
- Back Pain
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Cataracts
- Chest Pain
- CHF (congestive heart disease)
- Cold Extremities
- Constipation
- COPD/emphysema
- Cramps
- CVA (stroke/TIA)
- Dementia/Alzheimer's
- Depression
- Diabetes
- Digestion Problems
- Diagnosed emotional/mental disorders
- Dizziness
- Epilepsy
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Gallbladder disease/stones
- Glaucoma
- Gout
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Menstrual Cycle
- Kidney Infection
- Kidney Stones
- Liver disease/cirrhosis
- Loss of Memory
- Loss of Balance
- Loss of Smell
- Loss of Taste
- Lung disease
- Macular Degeneration
- Migraines
- Nosebleeds
- Pacemaker
- Parkinson's
- Polio
- Poor Posture
- Prostate Trouble
- Retinal Disease
- Sciatica
- Seizures
- Shortness of Breath
- Sinus Infection
- Sleep Problems/Insomnia
- Skin Sensitivity
- Smoked
- Spinal Curvatures
- Stroke
- Swelling of Ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other

Other:

Have you had any of these Cardiovascular Diseases? Please select all that apply.

☐ Myocardial infarction ☐ Hypertension ☐ Hypercholesterolemia ☐ Bypass surgery
☐ Coronary artery disease

Do you have Diabetes? If so what type?

○ Type I ○ Type II ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

☐ Ulcers ☐ Reflux ☐ IBS

Worker's Compensation

Who saw the accident? Title:

Who reported the accident? Title:

Type of windows: Type of shop:

Do you use hand or foot levers? ○ Yes ○ No Do you work overhead? ○ Yes ○ No

Are you tired when you go home? ○ Yes ○ No

Describe the accident?

Do you lift from?
○ Ground ○ Bench ○ Platform ○ Box ○ Pallet ○ Other

Do you have to reach?
○ Yes ○ No Explain:

Is your work area cluttered?
○ Yes ○ No Explain:

Do you push or pull?
○ Yes ○ No Explain:

Do you pick up or lift?
○ Yes ○ No How Much: How Often:

Do you lift in and out of a machine?
○ Yes ○ No If so, do you:

Type of Floor:
If other describe:

Type of ventilation:
If other describe:

Type of lighting:

If other describe:

Is your work area:

If other describe:

Do you have any other jobs?

Yes No If yes, what type:

Has outside help been hired?

Yes No If yes, why:

Do you use a cart?

Yes No Type of Wheels:

Condition of cart: Good Bad Other If other, explain:

# of carts being moved at once: Weight moved per day:

From where to where:

Auto Accident

Date & Time: Make & Model:

Street / Location: # of persons in your vehicle

Were you the: Were you:

Speed of your vehicle: Speed of their vehicle:

Were you wearing a seat belt? Yes No

Have you worked since this injury? Yes No

Are your work activities restricted? Yes No

Were there any witnesses? Yes No

Did the vehicle have airbags? Yes No

Did the airbags inflate? Yes No

Did the police arrive? Yes No

Police report filed? Yes No

Visited a Hospital or Doctor?

Yes No Name of hospital:

When did you go to the hospital?

How did you get to the hospital?

Was the Doctor a?

Were any X-rays taken? Yes No

Medication prescribed? Yes No

Were you rendered unconscious?

Yes No How long?

Traffic violation issued?

Yes No To Whom?

Retained an attorney?

Yes No Name: Phone:

In relation to the base of your skull, where was the headrest?

Impact to your vehicle came from?

The direction you were heading?

The direction they were heading?

The direction you were facing?

What did your vehicle impact?

Explain:

Strike anything in the vehicle?

Explain:

Describe the accident?

How did you feel right after?

Names of all persons in this accident:

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* **I agree with this statement of authorization**

Name of the Insured:
(Please Print)

Patient's/Guardian's signature: **Date:**

Signature

Clear Signature