PEERY FAMILY CHIROPRACTIC
NEW PATIENT INTAKE FORM

Date:_____ Referred by:_____

Name (Last):_____(First):_____M.I._____

Address:_____City:_____ZIP:_____

Home Phone:_____Work:_____

Cell: _____Email:_____

Date of Birth: _____ Age:_____ Social Security # _____

Sex: M___ F ___ Marital Status: Single__ Married__ Divorced__ Other ___

Employer:_____Occupation:_____

Emergency Contact:_____Relation:_____

Contact's Phone: _____ Cell:_____Work:_____

Have you seen a Chiropractor before? Y N Who?_____When:_____

Why chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain and discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid further relapses (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (Comprehensive Care). Peery Family Chiropractic offers some of the latest procedures for optimizing your nervous system.

Peery Family Chiropractic stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief__ Corrective Care__ Comprehensive Care__ Would like to discuss options w/ doctor_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. The practitioner at Peery Family Chiropractic does not participate in all HMO/PPO organizations. I understand that the Doctor's office will prepare any necessary forms to assist me in making collection from the insurance company. However, I clearly understand that all services rendered to me are my personal responsibility and any services which are not covered by insurance are my financial obligations.

Patient's Signature_____Date:_____

Guardians' Signature Authorizing Care_____Date:_____

Please list your major complaints in order of severity:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Complaint # 1: When did you first notice this condition? _____

Did it begin ☐ Immediately or ☐ Gradually? (Please describe briefly)_____

_____

What is the exact location of your symptoms? _____

_____

Do your symptoms spread? ☐ No ☐ Yes Where? _____

How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%)
☐ Seldom (25%) ☐ Rarely (less than 24%) _____

Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged

What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild

Rate your symptoms on a scale of 1 - 10 considering 1 (minimal) and 10 (severe/excruciating pain) _____

Is your pain ☐ Deep or ☐ Superficial

Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing

Are you experiencing any of the following associated symptoms? ☐ Pins & Needles ☐ Tingling ☐ Numbness
☐ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

☐ Sitting ____min	☐ Lying	☐ Lifting_____lbs.	☐ Bowel Movements	☐ Hot or Cold
☐ Standing	☐ Pushing	☐ Gripping	☐ Mental Activities	☐ _____
☐ Walking	☐ Pulling	☐ Coughing/Sneezing	☐ Bright Lights	☐ _____

_____

_____

_____

_____

Please indicate what helps you to relieve the pain.

☐ Lying	☐ Walking	☐ Rest	☐ Medications _____	☐ _____
☐ Sitting	☐ Standing	☐ Heat or Cold	☐ _____	

Please list what doctors you have seen for this condition, (Including diagnoses, treatment received, and any changes in your condition) _____

_____

_____

_____

_____

Please include any other relevant history in regards to this complaint. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Complaint # 2: When did you first notice this condition? _____
Did it begin ☐ Immediately or ☐ Gradually? (Please describe briefly)_____
_____
What is the exact location of your symptoms? _____
_____
Do your symptoms spread? ☐ No ☐ Yes Where? _____
How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%)
☐ Seldom (25%) ☐ Rarely (less than 24%) _____
Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1 - 10 considering 1 (minimal) and 10 (severe/excruciating pain) _____
Is your pain ☐ Deep or ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing
Are you experiencing any of the following associated symptoms? ☐ Pins & Needles ☐ Tingling ☐ Numbness
☐ Twitching of muscles If yes, please describe: _____
Please indicate what activities provoke (P) or aggravate (A) your condition:

☐ Sitting ___min	☐ Lying	☐ Lifting_____lbs.	☐ Bowel Movements	☐ Hot or Cold
☐ Standing	☐ Pushing	☐ Gripping	☐ Mental Activities	☐ _____
☐ Walking	☐ Pulling	☐ Coughing/Sneezing	☐ Bright Lights	☐ _____

_____
Please indicate what helps you to relieve the pain.

☐ Lying	☐ Walking	☐ Rest	☐ Medications _____	☐ _____
☐ Sitting	☐ Standing	☐ Heat or Cold	☐ _____	

Please list what doctors you have seen for this condition, (Including diagnoses, treatment received, and any changes in your condition) _____
_____
_____

Complaint # 3: When did you first notice this condition? _____
Did it begin ☐ Immediately or ☐ Gradually? (Please describe briefly)_____
_____
What is the exact location of your symptoms? _____
_____
Do your symptoms spread? ☐ No ☐ Yes Where? _____
How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%)
☐ Seldom (25%) ☐ Rarely (less than 24%) _____
Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1 - 10 considering 1 (minimal) and 10 (severe/excruciating pain) _____
Is your pain ☐ Deep or ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing
Are you experiencing any of the following associated symptoms? ☐ Pins & Needles ☐ Tingling ☐ Numbness
☐ Twitching of muscles If yes, please describe: _____
Please indicate what activities provoke (P) or aggravate (A) your condition:

☐ Sitting ____min	☐ Lying	☐ Lifting_____lbs.	☐ Bowel Movements	☐ Hot or Cold
☐ Standing	☐ Pushing	☐ Gripping	☐ Mental Activities	☐ _____
☐ Walking	☐ Pulling	☐ Coughing/Sneezing	☐ Bright Lights	☐ _____

Please indicate what helps you to relieve the pain.

☐ Lying	☐ Walking	☐ Rest	☐ Medications _____	☐ _____
☐ Sitting	☐ Standing	☐ Heat or Cold	☐ _____	

Please list what doctors you have seen for this condition, (Including diagnoses, treatment received, and any changes in your condition) _____

Past Medical History

Please include any of your previous conditions. If possible include Dates, Diagnosis, Treatment Received and any Residuals you still suffer from.

Utero, Birth, and Infancy:

Was your mother healthy when you were in utero? ☐No ☐Yes _____

Did she smoke or consume alcohol? ☐No ☐Yes _____

Where were you born? _____

Were you delivered vaginally or through cesarean section? *Circle one*

Were there any complications during your birth process? ☐No ☐Yes _____

Were you vaccinated? ☐No ☐Yes _____

Did you have normal neurological, structural, emotional, and social development? ☐No ☐Yes _____

_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas ☐none_____

Illnesses/Hospitalizations: ☐none _____

Surgeries: ☐none _____

Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, and social development?

☐No ☐Yes _____

_____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Athletics	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas ☐none_____

_____

Illnesses/Hospitalizations: ☐none _____

_____

Surgeries: ☐none _____

_____

Teens (ages 13 – 19)

Did you have normal neurological, structural, emotional, and social development?

☐No ☐Yes _____

_____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Athletics	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas ☐none_____

_____

Illnesses/Hospitalizations: ☐none _____

_____

Surgeries: ☐none _____

Females only: What age did you start your menses? _____ ☐Regular ☐Irregular

Twenties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Athletics	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐none_____

_____

Work Injuries ☐none_____

_____

Injuries, Accidents, Falls or Traumas ☐none_____

_____

Illnesses/Hospitalizations: ☐none _____

_____

Surgeries: ☐none _____

Thirties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Athletics	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐none_____

_____

Work Injuries ☐none_____

_____

Injuries, Accidents, Falls or Traumas ☐none_____

_____

Illnesses/Hospitalizations: ☐none _____

_____

Surgeries: ☐none _____

Forties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Athletics	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐none_____

_____

Work Injuries ☐none_____

_____

Injuries, Accidents, Falls or Traumas ☐none_____

_____

Illnesses/Hospitalizations: ☐none _____

_____

Surgeries: ☐none _____

Females only: Menopausal symptoms ☐none ☐yes _____

Family History

Mother ☐Alive & Well, age ___ ☐Deceased age ___ from what _____
Any health conditions _____
Father ☐Alive & Well, age ___ ☐Deceased age ___ from what _____
Any health conditions _____
Brother ☐Alive & Well, age ___ ☐Deceased age ___ from what _____
Any health conditions _____
Brother ☐Alive & Well, age ___ ☐Deceased age ___ from what _____
Any health conditions _____
_____
_____
Sister ☐Alive & Well, age ___ ☐Deceased age ___ from what _____
Any health conditions _____
Sister ☐Alive & Well, age ___ ☐Deceased age ___ from what _____
Any health conditions _____
_____
_____

Children: Ages _____ Any health conditions? _____
_____
Maternal Grandmother ☐A&W age ___ ☐Deceased age ___ from what? _____
Any health conditions _____
Maternal Grandfather ☐A&W age ___ ☐Deceased age ___ from what? _____
Any health conditions _____
Paternal Grandmother ☐A&W age ___ ☐Deceased age ___ from what? _____
Any health conditions _____
Paternal Grandfather ☐A&W age ___ ☐Deceased age ___ from what? _____
Any health conditions _____

Have any of your family members ever suffered from any of the following conditions?
☐Diabetes ☐Neurological Disorders _____ ☐Depression/Mental Illness _____
☐Heart Disease ☐Autoimmune Diseases _____ ☐_____
☐Stroke ☐Cancer _____ ☐_____

Medications: Please list your current medications and what taken for.
_____
_____
Vitamins and Minerals: Please list your current supplements and by whom prescribed.
_____
_____

Habits
Cigarettes ☐none How much per week?_____ Cigars ☐none How many per week? _____
Alcohol ☐none How many drinks per week?_____Type of alcohol _____
Coffee ☐none How many cups per week?_____
Recreational Drugs ☐none Types_____ Frequency_____ Years of Usage_____
Exercise ☐none Hours/Days per week?_____Types _____
Water ☐none Glasses per day?_____
Soft Drinks ☐none Amount per week_____Types _____
Sleep Average per night _____ Do you have difficulty falling asleep or staying asleep? ☐Yes ☐No_____
Hours of sleep desired per night? _____
Meals per days _____ What type of foods do you eat? _____
Do you consider your diet healthy? ☐Yes ☐No _____

DATE OF LAST:

Physical Examination: _____ By Whom?_____Results_____
Blood Work: _____ By Whom?_____Results_____
Bone Density Study _____ Results_____ Mammogram _____ Results _____
Pelvic Exam _____ Results_____ Self Breast Exam _____ Results _____
PSA Level _____ Results_____ Digital Prostate Exam _____ Results _____
Chest X-rays_____Results_____ EKG_____ Results_____ Echocardiogram_____Results_____
Spinal X-Rays _____ By Whom? _____ Where are they located? _____
MRI / CAT Scan _____ Results _____ Where are they located" _____
Other tests: _____

CHECK any of the following conditions you have HAD and CIRCLE anything you HAVE.

☐ Mental Disorders	☐ Diabetes	☐ Pneumonia	☐ Infectious Diseases _____
☐ Epilepsy	☐ Anemia	☐ Tuberculosis	☐ Fungal Infection _____
☐ Tumors	☐ Glaucoma	☐ Hepatitis _____	☐ Herpes _____
☐ Alcoholism	☐ Heart Disease	☐ Thyroid Disease	☐ Arthritis
☐ Drug Addiction	☐ Rheumatic Fever	☐ Parasites	☐ Autoimmune Disease
☐ Cancer	☐ Scarlet Fever	☐ Venereal Infection	☐ _____

NERVOUS SYSTEM
☐ Depression
☐ Memory Loss/Confusion
☐ Dizziness
☐ Fainting
☐ Convulsions
☐ Numbness
☐ Weakness
☐ Poor Balance / Coordination
☐ Twitches / Tremor
☐ Cold / Tingling Extremities
☐ Sleeping Difficulties
☐ Headaches

EENT
☐ Vision Problems
☐ Flashing Lights
☐ Black Spots
☐ Blurriness
☐ Hearing Loss
☐ Ringing in Ears
☐ Swallowing Difficulty

C-V
☐ Chest Pain
☐ Irregular Heartbeat
☐ High Blood Pressure
☐ Shortness of Breath
☐ Lung Problems / Congestion
☐ Varicose Veins
☐ Ankle Swelling

GI
☐ Poor / Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Frequent Diarreah
☐ Frequent Constipation
☐ Hemorrhoids
☐ Black / Bloody Stools
☐ Digestive Problems
☐ Lung Problems/Congestion
☐ Gas / Bloating After Meals
☐ Heartburn
☐ Weight Problems
☐ Gall Bladder Problems
☐ Liver Problems

GU
☐ Bladder Trouble
☐ Painful Urination
☐ Excessive Urination
☐ Incontinence
☐ Discolored Urination

MUSCULOSKELETAL
☐ Jaw Pain
☐ Difficulty Chewing
☐ Face Pain
☐ Neck Pain
☐ Arm / Elbow Pain
☐ Wrist / Hand Pain
☐ Mid Back Pain
☐ Lower Back Pain
☐ Thigh / Knee Pain
☐ Ankle / Foot Pain
☐ Difficulty Walking
☐ Leg / Arm Fatigue

REPRODUCTIVE
☐ Erectile Difficulties
☐ Sexual Dysfunction
☐ Menstrual Irregularity
☐ Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? ☐ Yes ☐ No
Do your Stools ☐ float ☐ sink

How many times a day do you urinate?_____ Is this consistent? ☐ Yes ☐ No _____
Do you experience any urgency, dribbling, incontinence? _____