New Patient Intake Form

Name _____ Date_____

Phone: _____ Email: _____

Age _____ Date of Birth _____ Height _____ Weight _____

Who referred you to PSC? _____

Do you have children? Yes / No -- If yes, what are their ages? _____

What is your occupation?

_____

Emergency Contact Name _____

Phone _____ Relationship _____

Health History

Please describe the reason for your visit.

_____

Rate your pain on a scale from 1-10: _____

Have you ever been to a chiropractor before? _____

Please list any major illnesses, injuries, or surgeries and include dates:

_____

_____

Please list any medications or supplements you are currently taking (include birth control).

_____

Please list any known allergies:

_____

Do you currently have or have you ever had any of the following?

- Headaches or migraines
- Dizziness or vertigo
- Repeated sinus or ear infections
- Hypertension/ Heart disease
- Stroke
- Shortness of breath
- Gastric reflux
- Abdominal pain
- Difficulty urinating / defecating
- Sexual dysfunction
- Leg cramps after being seated
- Extremity weakness/numbness
- Fatigue
- Difficulty sleeping at night
- Stress
- Depression
- Irritability or restlessness
- Unexplained weight loss or gain
- Diabetes
- Arthritis: RA / OA
- Osteoporosis
- Alcoholism
- Cancer: _____
- Other: _____

For Women Only:

Are you currently Pregnant? Yes / No / Uncertain

If applicable, please describe past pregnancies and births:

_____

Please describe menstrual cycles (cramping, bleeding, duration):

_____

Family History

Do you have a family history of any of the following conditions? If so, indicate who

Heart Disease _____ Cancer _____ Alcoholism _____

Lifestyle

What do you do for exercise on a regular basis?

_____

How many alcoholic beverages do you consume each week?

_____

Do you participate in recreational drug use?

_____

Do you use tobacco products? What

Products?_____

How often per day? _____ For how many years? _____

How much caffeine do you consume daily?

_____

Please describe your diet:

_____

Consent

I hereby give my consent for the doctor to perform a diagnostic examination as well as chiropractic treatment to manage my determined condition(s). The exam will include diagnostic muscular and neurological testing. Chiropractic treatment will include manual spinal and extremity manipulation which can result in a “popping” or releasing sensation. The risk associated with the adjustment is quite low and complications are extremely rare. The patient may experience mild to moderate soreness, or in rare cases, dizziness, nausea, fractures, or increased pain can occur. I have read this informed consent and willingly allow the doctor to proceed with diagnostics and care best suited for me.

_____ _____

Printed Name Date

_____ _____

Patient Signature Parent/Guardian Signature