EnWell Chiropractic & Acupuncture

Confidential Patient Intake Form

Today's Date: _____ Please fill out all the information before seeing the doctor

PATIENT INFORMATION

Name: (Last, First MI)_____ **Preferred Name**:_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SS#: _____ **Home Phone:** _____ **Cell:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status: Married / Other / Single**

Contact method: **home / cell / work** **Date of Birth** ____/____/_____ **Age** _____

TEXT patient reminders: YES / NO **Occupation**:_____ **Employer**:_____

***Who referred you to our office?** _____

EMERGENCY CONTACT INFORMATION

Full Name:_____

Home: _____ **Mobile:** _____

Relationship: Child / Parent / Spouse / Other**:**_____

Name of Previous Chiropractor: _____

Date of Last Chiropractic Adjustment:_____

Primary Care Physician: _____

Doctor's Phone: _____

What is your purpose of visit? □ Chiropractic & Acupuncture □ Chiropractic only □ Acupuncture only □ Ask the doctor

FINANCIAL INFORMATIO N If you use insurance, please provide the card to front desk for copy.

Insurance **Self-Pay (Cash)** **Personal Injury/Auto** **Other (please explain)**:_____

PRIMARY INSURANCE

Insurance Name:_____

ID#:_____**Group #:**_____

Name:_____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address:_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:**_____

SECONDARY INSURANCE

Insurance Name:_____

ID#: _____**Group#:**_____

Name:_____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt, I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature:_____ **Date:**_____

Guardian's Name:_____

Guardian's Signature:_____ **Date:**_____

EnWell Chiropractic & Acupuncture

Patient Case History

CURRENT CONDITION

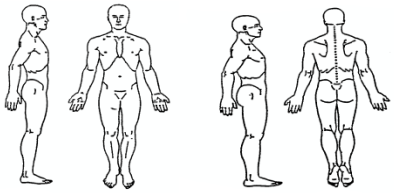
Describe Major Complaint: _____

Date of Injury ____/_____/_____ **Describe how this began:** _____

_____

_____

Grade Intensity/Severity of Complaint:
None / Mild / Moderate / Severe / Very Severe



Quality of the complaint/pain:

Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____ ____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any previous Surgery or Interventions in this area?** *(Describe)* _____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Family History:

Heart Disease	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather

Type of Cancer: _____

Any other family history that might be relevant: _____

Medications: List all your medication: _____

_____

_____

Vitamins and Supplements: (List all and frequency): _____

_____

_____

Past Health History: (Please list any past **surgery**, **hospitalization**, **Major Injury/Trauma** including fracture) **When? Why?**

_____

_____

_____

_____

Habits: Cigarettes – Yes / No If yes, how many a day? _____ Alcohol- Yes / No If yes, How much a day? _____

Coffee – Yes /No If yes, How many cups a day? _____ Rec Drugs- Yes / No If yes, List_____

Water Intake- How much? _____ Sweet / Sugar Intake – How much? _____

REVIEW OF SYSTEM

Are you ***currently*** experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- □Recent Weight Change
- □Fever
- □Fatigue
- □*None in this Category*

Musculoskeletal:
- □Low Back Pain
- □Mid Back Pain
- □Neck Pain
- □Arm Problems _____
- □Leg Problems _____
- □Painful Joints
- □Stiff/Swollen Joints
- □Muscle Spasms/Cramps
- □ Broken Bones_____
- □ Other: _____
- □*None in this Category*

Neurological:
- □Numbness or tingling sensations
- □Loss of Feeling
- □Dizziness or light headed
- □Frequent or Recurrent Headaches
- □Convulsions or seizures
- □Tremors
- □Stroke
- □Have you ever had a head injury?
- □Ever been in an auto accident?
- □ Other: _____
- □*None in this Category*

Mind/Stress:
- □Nervousness
- □Depression
- □Sleep Problems
- □Memory Loss or Confusion
- □Other: _____
- □*None in this Category*

Genitourinary:
- □Sexual Difficulty
- □Kidney Stones
- □Burning/Painful Urination
- □Change in force/strain w Urination
- □Frequent Urination
- □Blood in Urine
- □Incontinence or Bed Wetting
- □Other:
- □*None in this Category*

Gastrointestinal:
- □Loss of Appetite
- □Blood in Stool
- □Change in Bowel Movements
- □Painful Bowel Movements
- □Nausea or Vomiting
- □Abdominal Pain
- □Frequent Diarrhea
- □Constipation
- □ Other: _____
- □*None in this Category*

Cardiovascular & Heart:
- □Chest Pains
- □Blood Pressure Problems
- □Swelling of Hands, Ankles, or Feet
- □Heart Problems
- □ Other: _____
- □*None in this Category*

Respiratory:
- □Difficulty Breathing
- □Persistent Cough
- □Coughing Blood
- □Asthma or Wheezing
- □Lung Problems
- □ Other: _____
- □*None in this Category*

Eyes and Vision:
- □Wear contacts/glasses
- □Blurred or double vision
- □Glaucoma
- □Eye disease or injury
- □ Other: _____
- □*None in this Category*

Ears, Nose and Throat:
- □Bleeding gums / mouth sores
- □Bad Breath or bad taste
- □Dental Problems
- □Swollen throat or voice change
- □Swollen glands in neck
- □Ringing in the ears
- □Ear - Ache/Ringing/Drainage
- □Sinus / Allergy problems
- □Nose Bleeds
- □Hearing Loss
- □ Other: _____
- □*None in this Category*

Endocrine, Hematologic, and Lymphatic:
- □Thyroid problems
- □Diabetes
- □Excessive Thirst or urination
- □Cold Extremities
- □Heat or Cold intolerance
- □Change in hat or glove size
- □Dry skin
- □Glandular or hormone problem
- □Swollen Glands
- □Anemia
- □Easily Bruise or Bleed
- □Transfusion
- □Immune system disorder
- □ Other: _____
- □*None in this Category*

Skin and Breasts:
- □Rash or Itching
- □Change in Skin Color
- □Change in hair or nails
- □Non-healing sores
- □Change of appearance of a mole
- □Breast Pain
- □Breast Lump
- □Breast Discharge
- □Other: _____
- □*None in this Category*

Women Only:

Are you pregnant?

□ **Yes -** ***Due Date*** ___/___/___

□**No -** ***Last Menstrual Period***

___/___/___

- □Infertility
- □Painful or Irregular periods
- □Vaginal Discharge
- □Other: _____
- □*None in this Category*

Pregnancies with Outcome & Date:

_____

_____

_____

Is there anything else you would like Dr. Take Horii to know?: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of Chiropractic care.)

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____