EnWell Chiropractic & Acupuncture

Confidential Patient Intake Form

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

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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**:______________

By selecting YES for text reminders, you allow us to contact you by texts and emails regarding your appointments, updates, and other important information from Enwell chiropractic at the telephone number provided above. You may opt-out of receiving text (SMS) messages from the Clinic or our business partners at any time by replying with the word STOP to opt-out from the mobile device receiving the messages or simply let us know at any time.

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

EMERGENCY CONTACT INFORMATION

Full Name:______________________________ **Name of Previous Chiropractor**: ____________________

Home: ______________ **Mobile:** ______________ **Date of Last Chiropractic Adjustment:**________________

Relationship: Child / Parent / Spouse / Other:__________ **Primary Care Physician:** ______________________

Doctor's Phone: ____________________________

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

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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 /Gurdian's Signature:_________________________________ **Date:**______________________

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Patient Case History

CURRENT CONDITION

Describe Major Complaint: ____________________

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

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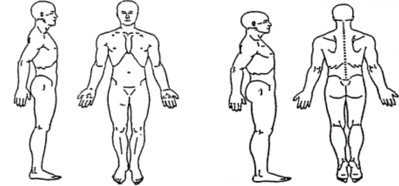
____

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?**

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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?** ____________________

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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:

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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_______________