Healthy For Life
Family Wellness
Chiropractic Clinic

New Patient Intake Form

1 - PATIENT INFORMATION

Date: _____

Name: _____
first full middle last

Nickname: _____

Address: _____

City: _____

State: _____

Zip: _____

Birthdate: _____

Soc. Sec #: _____

Email: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Nonstudent ☐ Full time student ☐ Part time student

Occupation: _____

Employer: _____

Spouse: _____

Birthdate: _____

Soc. Sec #: _____

Occupation: _____

Employer: _____

How did you find out about our office?

_____

2 - PAYMENT INFORMATION

Please check the appropriate category regarding payment of services:

- ☐ Cash – I have no insurance.
- ☐ I do have personal insurance that may cover chiropractic services.
- ☐ I was in an automobile accident .
- ☐ I was in a work-related accident.
- ☐ I was injured at a public facility.

If you have personal insurance you think may cover your care, please fill out the below information.

Insurance Company: _____

Group #: _____

Policy #: _____

Subscribers Name: _____

Relationship to Patient: _____

Birthdate: _____

Soc. Sec. #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature Date

3 – PHONE NUMBERS

Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

Which above that is the best number to reach you?
☐ Home ☐ Work ☐ Cell

4 – FAMILY MEMBERS

Name (include age)	Any Health Conditions?
1.	
2.	
3.	
4.	

5 – MEDICATIONS

Name	Reason Taking
1.	
2.	
3.	
4.	

6 – VITAMINS

Name	Reason Taking
1.	
2.	
3.	
4.	

7 – YOUR HEALTH PROFILE

Why This Form is Important:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. We are interested in what may have caused your problem in addition to what symptoms are actually affecting you now. Our mission is to help you achieve your health goals…whether that be recovery from a specific ailment or life long health and wellness. On a daily basis we experience mental, physical and chemical stresses that can accumulate and result in loss of health potential. Answering the following questions will give us a profile our specific factors in your life that may be contributing to less than optimal health.

Dr. Kevin Unterreiner is the developer and a practitioner of the Whole Body Analysis™ system for finding and correcting imbalances in the structural, chemical and energy systems of the body. This system combines the benefits of Chiropractic, Nutrition, Applied Kinesiology and Chinese meridian therapy.

We are honored to serve you and look forward to assisting you fulfill your inborn health potential.

a. Please rate your overall health status: *(Poor)* 1 2 3 4 5 6 7 8 9 10 *(Excellent)*

b. What are your health goals? _____

_____

c. Are you healthier today than you were 5 years ago? Yes No

d. Have you had previous chiropractic care? Yes No If yes, when was your last visit? _____

e. Were you aware that:

- Doctors of Chiropractic have more classroom hours of education than medical doctors and go to school a minimum of 6 years? Yes No
- *Chiropractors work with the nervous system?* *Yes No*
- The nervous system controls and coordinates all functions and systems of the body? Yes No
- *Chiropractic is the largest natural health care profession in the world?* *Yes No*
- Children, even during birth, may develop imbalances/ misalignments in their spine and that studies have shown kids who get regular chiropractic care have fewer ear infections, less colic, receive fewer prescriptions, experience fewer colds and are overall healthier? Yes No

f. Have you ever had a doctor that you felt really understood your problem, listened to you and your needs, explained their analysis in a way you could understand and that made sense, and truly cared about you as a person? Yes No

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8 – MEDICAL HISTORY

Please list the cause of death and age of any immediate family members (parents or siblings):

_____
_____
_____
_____

Please circle any of the following illnesses/ conditions you have had:

Pneumonia	Mumps	Influenza
Small pox	Pleurisy	Polio
Chicken pox	Arthritis	Tuberculosis
Diabetes	Epilepsy	Cancer
Anemia	Heart disease	Measles
Thyroid disorder	Eczema	Concussion
Depression	Meningitis	High cholesterol
Rheumatic fever	Whooping cough	High blood pressure

Surgeries Date and Reason

1. _____ _____
2. _____ _____
3. _____ _____

Previous Traumas *(include date and description)*

1. _____
2. _____
3. _____

Pregnancies *(include year and outcome):*

1. _____
2. _____
3. _____

Are you pregnant? Yes No Not sure

9 – CURRENT HEALTH CONDITIONS

List up 3 complaints below and answer the following questions regarding each. List your primary complaint as #1.

List your complaint(s) here:	1. _____	2. _____	3. _____
a. When did you first experience this problem?	_____	_____	_____
b. How did this problem first begin?	_____ _____ _____	_____ _____ _____	_____ _____ _____
c. How often do you experience this problem?	_____	_____	_____
d. Rate intensity of this problem: (1 = mild; 10 = extreme) - At its best - At its worst	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
e. Describe how it feels (eg achey, burning, stabbing, sharp, etc.):	_____ _____	_____ _____	_____ _____
f. Describe the location of pain:	_____ _____	_____ _____	_____ _____
g. What makes it better?	_____ _____	_____ _____	_____ _____
h. What makes it worse?	_____ _____	_____ _____	_____ _____
i. Does the pain radiate to other areas? If yes, explain where.	_____	_____	_____
j. Is this problem getting better, worse or staying the same?	better worse same	better worse same	better worse same
k. What time of day does this problem affect you the most?	_____	_____	_____
l. What have you tried to do to relieve this problem? (previous treatments)	_____ _____	_____ _____	_____ _____
m. Have you seen other doctors for this problem (if yes, list)?	_____	_____	_____

List any known allergies: _____

Have you ever been tested for food allergies? no yes (if yes, list) _____

10 – LIFESTYLE AND SOCIAL HISTORY

Job Description: _____

Work Hours per week ____ Occupational Stress Level (1-10) ____ Personal Stress Level (1-10) ____

Recreational Activities: _____

Circle all that apply: smoke cigarettes – drink alcohol – drink coffee – exercise regularly – get enough sleep

11 – RECENT MEDICAL HISTORY

Please check any of the following you have had in the past 6 months:

MUSCULOSKELETAL
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/ stiffness
- ☐ Walking problems
- ☐ Difficulty chewing/ clicking jaw
- ☐ Hand pain
- ☐ Elbow pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ ankle pain

NERVOUS SYSTEM
- ☐ Numbness
- ☐ Anxiety
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Fainting
- ☐ Depression
- ☐ Convulsions
- ☐ Seizure
- ☐ Tingling extremities
- ☐ Disturbed/ poor sleep

GENITOURINARY
- ☐ Bladder trouble/ infection
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Discolored

GASTROINTESTINAL
- ☐ Poor/ excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Weight trouble
- ☐ Abdominal cramps
- ☐ Gas/ bloating after meals
- ☐ Heartburn
- ☐ Black/ bloody stools
- ☐ Colitis
- ☐ Irritable bowel
- ☐ Non-formed (loose) stool

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Headaches
- ☐ Fever

EYES, EARS, NOSE, THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Ear aches
- ☐ Stuffy nose
- ☐ Sinus infections

HEART AND LUNGS
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems/ congestion
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke
- ☐ Blocked/ clogged arteries
- ☐ High cholesterol

FEMALE
- ☐ Menstrual irregularity
- ☐ Menstrual cramps
- ☐ Vaginal pain/ infection
- ☐ History of breast cancer
- ☐ Breast pain/ lumps
- ☐ Yeast infections
- ☐ Infertility/ trouble conceiving
- ☐ Other: _____

MALE
- ☐ Prostate
- ☐ Sexual dysfunction
- ☐ Difficulty with urination
- ☐ Other: _____

12 – HEALTH OBJECTIVES

Please identify your health objectives (check all that apply):

- ☐ I would like to find out what is causing my problem(s).
- ☐ I am interested in learning what I can do to help correct and prevent future problems from developing.
- ☐ I would like a Health Development Program designed for me (no extra charge) … this is a step by step plan to help you regain and maintain optimal health.

Thank you for the opportunity to assist you in your recovery and/ or maintenance of optimal health and we look forward to helping you live a healthier life, naturally!

Dr. Kevin Unterreiner and Staff