North Country Chiropractic Center, PLLC

PATIENT INTAKE INFORMATION

The following information is needed for our files so we can better serve you.
Please fill in all appropriate portions of the form. If you need help, please ask the receptionist.

Today's Date: _____ Full name: _____

Home #: _____ Work #: _____ Cell #: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Age: _____ Sex: M F
Marital Status: ❒ S ❒ M ❒ CU ❒ D ❒ W Social Security No.: _____
Birth Date: ____/____/____ Occupation: _____

Employer (name & address): _____
_____

Name of Spouse: _____

Spouse's Employer (name, address & phone): _____
_____
_____

Name & Phone of Person to contact in case of an emergency (other than spouse): _____
_____

Name & Address of Primary Care Physician: _____
_____

Who referred you to our clinic? _____

Have you had previous chiropractic care? ❒ Yes ❒ No If yes, with whom and when?
_____

Do you have a pacemaker or any implants in your body? ❒ Yes ❒ No

Age of mattress: _____ ❒ Comfortable ❒ Uncomfortable ❒ Do you use a bed board? ❒ Yes ❒ No

What type of care are you seeking at this office?
❒ Pain relief only ❒ Correction of underlying problem
❒ Preventive care

PLEASE ANSWER THE FOLLOWING QUESTIONS, ALL OF WHICH WILL HELP US BETTER ASSESS YOUR CONDITION.

What is your major complaint? _____
_____

What do you believe is wrong with you? _____
_____

When did this condition start? _____ were you at work? ❒ Yes ❒ No

How did it happen? (describe in your own words) _____
_____
_____
_____

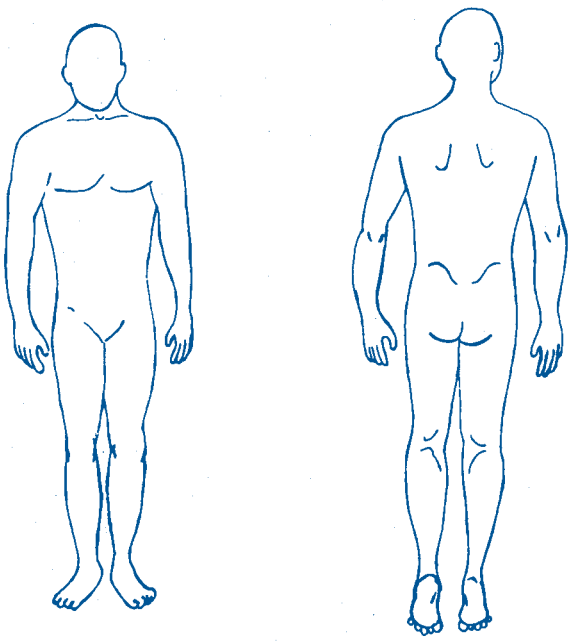
Please continue on other side

Please mark the diagram with the appropriate symbols to describe your pain/sensations:

Numbness ☰ ☰ Pins and Needles ○ ○ ○ ○ ○ ○

Burning x x x x x x Aching AAA AAA

Stabbing / / / / / / / / / /



Rate pain on a scale of 0-10
with 0 being no pain and 10 the worst pain ever. _____

— PLEASE CHECK ALL APPROPRIATE BOXES FOR QUESTIONS BELOW. —

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Comes and goes
Is it better in the morning ❒, at night ❒, as the day goes on ❒?
Is it worse in the morning ❒, at night ❒, as the day goes on ❒?

What makes your symptoms worse?

❒ Coughing ❒ Sneezing ❒ Sitting
❒ Getting up from sitting ❒ Ice ❒ Heat
❒ Any movement ❒ Other

What relieves your symptoms?

❒ Ice ❒ Heat ❒ Movement
❒ Bed rest ❒ Exercise ❒ Stretching
❒ Medication (type)
❒ Other

What treatment have you had thus far for this condition? (Starting with initial treatment and ending with the most recent) _____

Have you had any x-rays for this condition? ❒ Yes ❒ No. If yes, where and when?

Have you had this condition in the past? ❒ Yes ❒ No. If yes, please describe when and what treatment you had _____

Check any illness or conditions you have had:

❒ Diabetes	❒ Glaucoma	❒ Heart Trouble	❒ STD	❒ Thyroid
❒ Vein Trouble	❒ Cancer	❒ Asthma	❒ Jaundice	❒ Osteoporosis
❒ Bleeding Tendencies	❒ Tuberculosis	❒ Pneumonia	❒ Stroke	❒ Other
❒ Kidney Disease	❒ Rheumatic fever	❒ Nervous Disorder	❒ MS	❒ TIA

❒ Describe briefly _____

Have you had any serious injuries, broken bones, etc.? ❒ Yes ❒ No. List _____

_____

List previous operations and dates (approximate if necessary) _____

_____

_____

Have you taken cortisone - type (Prednisone) or anticoagulant (Heparin, Coumadin) drugs in the past?

❒ Yes ❒ No. If yes, what and for how long? _____

_____

Do you have any known drug sensitivities? ❒ Yes ❒ No. What? _____

_____

_____

Name, or otherwise identify medicines now or recently used _____

_____

_____

Have you experienced any unexplained weight loss/gain in the last 6 months? ❒ Yes ❒ No. If so, how much? _____

Do you ever get dizzy, nauseous, light-headed or have blurred vision upon turning your head?

❒ Yes ❒ No

Has anyone in your family had cancer, heart problems, diabetes, spinal problems/surgery, kidney disorders, stroke, tuberculosis, rheumatic fever, or other serious illness?

Father _____
Mother _____
Sisters _____
Brothers _____
Grandparents _____

Do you smoke?	❒ Yes	❒ No	If yes, how many packs a day?	_____
use alcohol?	❒ Never	❒ Occas.	❒ Frequent	How much? _____
exercise?	❒ Yes	❒ No	How often?	_____

Do you wear any lifts or supports in your shoes? ❒ Yes ❒ No. If so, what type?

_____

Are there any stressful situations currently affecting your quality of life? ❒ Yes ❒ No

Describe briefly _____

_____

Please continue on other side

WOMEN ONLY: Are you or might you be pregnant? ❒ Yes ❒ No

Last menstrual period _____

Are you now taking ❒, Or have you ever taken ❒ birth control pills? If yes, when and for how long?

_____

— AUTHORIZATION FOR EXAMINATION —

I, the undersigned, hereby authorize the physicians at North Country Chiropractic Center to administer any examination and/or treatment as is necessary, and to perform appropriate diagnostic and therapeutic procedures as are considered necessary on the basis of findings during the course of said examination and/or treatment.

I certify that no guarantee has been made as to the results that may be obtained. I understand that I am ultimately responsible for payment for services rendered, regardless of any arrangements I may have with an insurance company or attorney.

I understand that if I cannot keep a scheduled appointment I must leave a message cancelling the appointment so that the time slot may be made available for another patient in need. If I fail to notify the office of a cancellation I understand that I may be charged for the missed appointment. Interest at the rate of 1% per month (12% per annum) will be charged to any unpaid balance over 30 days.

Date _____ Signed _____
Patient

Signed _____
Parent or Guardian, if applicable

DO NOT FILL OUT THESE BOXES

WORKERS COMP **EMPLOYER** _____ **ADDR WHERE OCCUR** _____

PHONE _____ **SUPERVISOR** _____ **NOTIFIED Y N** _____

MISSED WORK _____

DID THEY REFER YOU Y N HAVE YOU HAD A WC CLAIM BEFORE? Y N

WHEN _____

AUTO **PT. WAS (driver/passenger) IN (front/back) WHAT HAPPENED** _____

_____

_____

PT WAS FACING (straight/rt/lt) ANTICIPATE IMPACT Y N SEAT BELT Y N HEADREST Y N

INSUR. CO. RESPONSIBLE FOR PAYMENT _____

HAVE YOU BEEN CONTACTED BY AN ADJUSTER Y N _____

HAVE YOU RETAINED AN ATTORNEY Y N (name) _____