New Patient Intake

LIMITLESS CHIROPRACTIC

About the Patient

Name: _____ Today's Date: _____ Birth Date: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Gender: _____
Significant Other's Name: _____
Kid's Names and Ages: _____
Your Employer: _____ Type of Work: _____
E-Mail Address: _____ Have you been to a chiropractor before? ☐ No ☐ Yes
Emergency Contact: _____ Phone Number: _____
Name of Medical Doctor(s): _____
Referred By: _____

Patient Condition

Chief Complaint: _____
When did symptoms start? _____
How did symptoms start? _____
What makes it better? _____
What makes it worse? _____
How much of the day do you feel symptoms? _____
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Are the symptoms getting:
☐ Worse ☐ Better ☐ Staying the Same
Have you had anything like this before? ☐ No ☐ Yes
Describe your symptoms (check all that apply):
☐ Dull Ache ☐ Numb ☐ Throbbing ☐ Tightness
☐ Burning ☐ Tingling ☐ Stabbing ☐ Shooting
☐ Sharp ☐ Radiating. If Radiates, to where?: _____
Please rate the intensity of your symptoms from 0-10 with 10 being the worse possible:
0 1 2 3 4 5 6 7 8 9 10
Please select symptom intensity:
☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable
What have you tried that makes the symptoms better?:
☐ Medication ☐ Chiropractic ☐ Physical Therapy
☐ Massage Therapy ☐ Surgery ☐ Acupuncture
☐ Other: _____
What activities does this interfere with? (check all that apply):
☐ Prolonged sitting ☐ Walking ☐ Prolonged standing
☐ Sleeping ☐ Bending ☐ Social/Recreational activities
☐ Lifting ☐ Personal care (washing, dressing, etc.)
☐ Traveling ☐ Other: _____

Additional Conditions (if applicable)

Additional Complaint: _____
When did symptoms start? _____
How did symptoms start? _____
What makes it better? _____
What makes it worse? _____
How much of the day do you feel symptoms? _____
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Are the symptoms getting:
☐ Worse ☐ Better ☐ Staying the Same
Have you had anything like this before? ☐ No ☐ Yes
Describe your symptoms (check all that apply):
☐ Dull Ache ☐ Numb ☐ Throbbing ☐ Tightness
☐ Burning ☐ Tingling ☐ Stabbing ☐ Shooting
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☐ Other: _____
What activities does this interfere with? (check all that apply):
☐ Prolonged sitting ☐ Walking ☐ Prolonged standing
☐ Sleeping ☐ Bending ☐ Social/Recreational activities
☐ Lifting ☐ Personal care (washing, dressing, etc.)
☐ Traveling ☐ Other: _____

Are you pregnant? ❑ No ❑ Yes If yes, Due Date: _____

Previous Injury and Treatment History

1. List any past auto collisions: _____ Was any care received? _____
2. List any past work injuries: _____ Was any care received? _____
3. List any past sport, recreational, or home injuries: _____
4. Please describe any past conditions and treatment received: _____
   _____
5. Please list any past hospitalizations and surgeries: _____
   _____

General Health History

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Depression
☐	☐	Migraines	☐	☐	Urinary Problems
☐	☐	Shortness of Breath	☐	☐	Easy Bruising
☐	☐	Allergies/Asthma	☐	☐	Tobacco Use
☐	☐	Medication Side Effects	☐	☐	Dental Problems
☐	☐	Diabetes	☐	☐	Fibromyalgia
☐	☐	Cold Hands or Feet	☐	☐	Blood Thinner use
☐	☐	Muscle aches	☐	☐	HIV Positive
☐	☐	Trouble Walking	☐	☐	Cancer
☐	☐	Leg/Foot Numbness	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	High BP/Stroke History
☐	☐	Gall Bladder Trouble	☐	☐	Low Blood Pressure
☐	☐	Ringing in Ears	☐	☐	High Cholesterol
☐	☐	Ear Problems	☐	☐	Digestive Problems
☐	☐	Sleeping Problems	☐	☐	Pain all Over Tension
☐	☐	Vision Problems	☐	☐	Chest Pains
☐	☐	Thyroid Problems	☐	☐	TMJ
☐	☐	Liver Disease	☐	☐	Heart Pacemaker
☐	☐	Kidney Problems	☐	☐	Heart Problems
☐	☐	Other			

1. List any medications you are taking: _____

_____

2. Please list all doctors you are currently seeing: _____

_____

_____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: _____

Is there any other family history you want us to know? _____

_____

Authorization and Consent

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Limitless Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____

Patient / Parent (This represents a long term authorization for all occasions of service) Date

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