BEECHMONT
CHIROPRACTIC CENTER

PATIENT INTAKE

PERSONAL INFORMATION:

PATIENT NAME: _____TODAY'S DATE: _____

WHAT YOU PREFER TO BE CALLED: _____

MAILING ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

HOME PHONE: _____CELL PHONE: _____

BIRTHDATE: _____SOCIAL SECURITY NUMBER: _____

E-MAIL ADDRESS:_____

SEX: MALE / FEMALE MARITAL STATUS: SINGLE / MARRIED / DIVORCED

DO YOU HAVE CHILDREN? YES/NO How many?_____

EMPLOYER NAME:_____OCCUPATION:_____

EMPLOYER ADDRESS: _____WORK PHONE:_____

EMPLOYER CITY: _____STATE:_____ZIP:_____

SPOUSE/SIGNIFICANT OTHER NAME: _____

NAME & PHONE OF EMERGENCY CONTACT:_____

REFERRED BY:_____

PARENT OR GUARDIAN INFORMATION: (<u>for minor only</u>)

NAME: _____RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

TELEPHONE: _____CELL PHONE: _____

INSURANCE

NAME OF YOUR HEALTH INSURANCE: _____

ADDRESS:_____

INSURANCE PHONE:_____

INSURED'S ID#_____ GROUP #_____

INSURED'S NAME:_____DATE OF BIRTH: _____

BEECHMONT
CHIROPRACTIC CENTER

PRESENT COMPLAINT:

PLEASE DESCRIBE YOUR SYMPTOMS(S) BRIEFLY:

1._____

2._____

3._____

4._____

ARE THESE SYPTOMS DUE TO AN ACCIDENT: ____YES/___NO **DATE OF ACCIDENT: _____**

IF YES, TYPE OF ACCIDENT: ____AUTO/____WORK/___OTHER

MEDICAL HISTORY:

ANEMIA	MUSCULAR DYSTROPHY	RHEUMATIC FEVER	HIGH/LOW BLOOD PRESSURE	BACK PAIN	CANCER
EPILEPSY	MULTIPLE SCLEROSIS	ALLERGIES	TUBERCULOSIS	SINUS TROUBLE	HIV
ASTHMA	HEADACHES	ALCOHOL/DRUG ABUSE	HEART TROUBLE	NUMBNESS	POLIO
DIABETES	CONCUSSION	DIZZINESS/VERTIGO	DIGESTIVE ORDERS	NECK PAIN	HEPATITIS
ARTHRITIS	ARTIFICIAL JOINTS	VENEREAL DISEASE	PSYCHIATRIC PROBLEMS	CHEMOTHERAPY	STROKE

HAVE YOU HAD ANY OPERATIONS OR SURGERIES: YES / NO IF YES, LIST THE DATE AND SURGERY(S) PERFORMED:

_____

_____

LIST THE DATE OF ANY PREVIOUS ACCIDENTS OR FALLS: AUTO / RECREATIONAL / WORK / OTHER: _____

LIST ANY BROKEN BONES/ FRACTURES/ DISLOCATIONS: _____

FAMILY HEALTHY HISTORY: _____

WOMEN ONLY: ARE YOU PREGNANT: YES / NO IF YES, HOW MANY WEEKS_____ ARE YOU NURSING: YES/NO

DO YOU SMOKE: YES / NO DO YOU DRINK: YES / NO IF YES, HOW OFTEN:_____

LIST ANY MEDICATIONS YOU ARE TAKING:_____

_____

ARE YOU TAKING ANY OF THE FOLLOWING: BLOOD THINNERS? YES/NO PAIN KILLERS? YES/NO

I ATTEST THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNATURE OF PATIENT DATE

BEECHMONT
CHIROPRACTIC CENTER

PAIN DRAWING

Name: _____ Date: _____

REASON FOR TODAY'S VISIT: EMERGENCY / NEW INJURY / OLD INJURY / CHRONIC PAIN / WELLNESS

WHEN DID YOUR CONDITION OCCUR? _____ WHERE DID YOUR INJURY OCCUR? _____

PLEASE EXPLAIN WHAT HAPPENED: _____

IS YOUR CONDITION INTERFERING WITH YOUR : WORK: YES/NO SLEEP: YES/NO DAILY ROUTINE: YES/NO

HAVE YOU BEEN TREATED BY A MEDICAL DOCTOR FOR THIS CONDITION? YES/NO IF SO, WHERE:_____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? YES/NO CLINIC OR DOCTOR NAME:_____

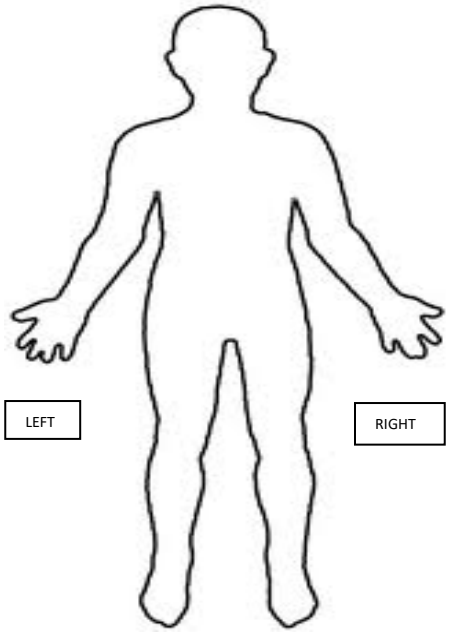
SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort on the body below. Mark all areas with the appropriate symbols.

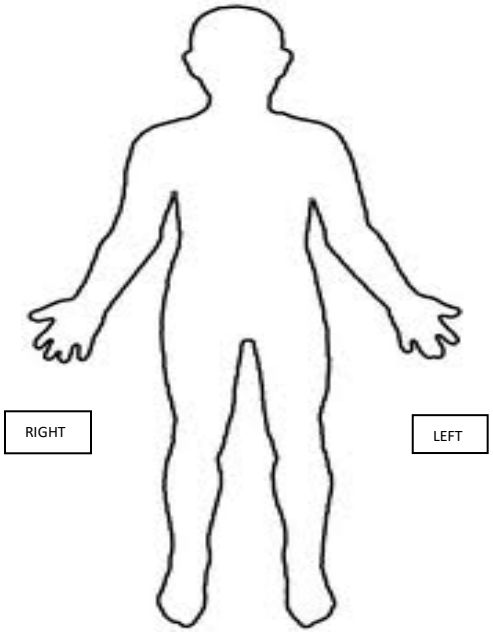
Description	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol	N	P	B	A	S

(Circle any area of pain not represented by a symbol.)

BACK



FRONT



INDICATE YOUR PAIN LEVEL BELOW

(NO Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)