

Dixon Center Medical Intake Form

Whom may we thank for referring? _____

Patient Information

Full Legal Name: _____ Nickname/preference: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best Number to Reach You During Day: Home Cell Work

E-mail address _____ Date of Birth _____
Social Security Number: _____ Marital Status: married single divorced widowed
Race: _____ Ethnicity: Declined to state Hispanic or Latino Not Hispanic or Latino
Employer: _____ Occupation: _____
Spouse Name: _____ Spouse Employer/Occupation: _____
Emergency Contact Information: _____ # _____
Primary Care Physician (PCP) _____ Phone: _____
Would you like to receive appointment reminders? Yes No If yes, how? Text Email Call

Insurance Information

Primary Subscriber Name: _____ DOB: _____ SSN: _____
Case Type: Cash (no insurance) Insurance Medicare Automobile Accident Workers Comp

Personal Medical History

Allergies:

Please list all known allergies and reactions to:

Please list any other allergies (environmental, chemical, food...)

Check this box if you have no known allergies

Medications:

Please list all of your medications including the dose and how often you take them.

Vitamins/Supplements:

Please list any vitamins, minerals, or other supplements you take: (ex: fish oil)

Personal Medical History cont

Medical / Family History

Please check the appropriate column if YOU or an IMMEDIATE family member (parent, sibling, child) have or had any of the following conditions:

Condition	Yourself	Family Member
Heart Attack		
Aneurysm		
High Blood Pressure		
Blood Clots		
Stroke		
High Cholesterol		
Cancer (type _____)		
Diabetes		
Thyroid Problems		
Obesity		
Seizures		
Liver Problems		
Asthma		
Seasonal Allergies		
Chronic Bronchitis or Emphysema		
Sleep Apnea		
Osteoporosis		
Rheumatoid Arthritis/Lupus		
Gout		
Kidney Disease		
Kidney Stones		
Depression		
Anxiety		
Other psychiatric Disorders		
Substance Abuse/Alcoholism		
Hysterectomy		
Hormone Replacement Therapy		
Do you smoke?	Y N	If yes, how much daily/weekly:
Have you ever smoked?	Y N	If yes, please indicate when you quit smoking:
Do you drink?	Y N	If yes, how much daily/weekly:

Surgical History

Please check the appropriate box if you have had the listed surgery.

√ This Box	Surgery	Year
	Appendix	
	Hernia	
	Gallbladder	
	Hysterectomy	
	Removal of Ovary	
	Spine Surgery	
	Hip or Knee Surgery	
	Eye Surgery	
	Cancer Surger (specify)	
	Other (specify)	

Screening/Prevention

When was your last.....?

Physical _____

Cholesterol Check _____

Diabetes Check _____

Colonoscopy _____

Men _____

Prostate Exam _____

Women _____

Mammogram _____

Papsmear _____

Bone Density _____

Flu Shot _____

Tetanus Shot _____

Patient Signature

Date

Dixon Center Chiropractic Initial Intake Form

Patient Name _____ DOB _____

Condition Information

What is your major complaint? _____

Any other complaints? _____

What activities aggravate your condition? _____

Is this condition progressively getting worse? Yes No Constant Comes and Goes

Have you ever had chiropractic Care? Yes No

General Symptoms (check symptoms you currently have or have had in the past year)

"X"	General	"X"	Genito-Urinary	"X"	Cardiovascular	"X"	Skin
	Bruises easily		Frequent Urination		Chest Pain		Bruise Easily
	Chills		Lack of bladder control		High Blood Pressure		Change in Moles
	Dental Problems		Painful Urination		Low Blood Pressure		Rashes
	Depression				Swelling of ankles		
	Difficulty Sleeping		Gastrointestinal		Varicose Veins		
	Dizziness		Appetite Poor		eye/ear/nose/throat		Women Only
	Fainting		Bloating		Blurred Vision		Bleeding between periods
	Fever		Bowel changes		Double Vision		Extreme menstrual pain
	Headache		Constipation		Earache		Hot flashes
	Loss of sleep		Diarrhea		Hoarseness		Other:
	Loss of weight		Hemorrhoids		Loss of hearing		Date of last period:
	Nervousness		Indigestion		Persistent cough		Are you pregnant?
	Sweats		Nausea		Ringling in ears		Number of children?
	Tiredness		Stomach pain		Sinus problems		
	Weight Gain		Vomitting				

NECK, BACK & EXTREMITIES (check symptoms you currently have or have had in past year)

"X"	Neck	"X"	Mid Back	"X"	Low Back
	Pain in neck		Decreased motion		Low back pain
	Sinus Pain		Mid back pain		Low back stiffness
	Neck stiffness		Mid back stiffness		Low back weakness
	Neck weakness		Pain front to back		Pinched nerve
	Decreased Motion		Muscle spasms		Low back feels out of place
	Pinched nerve		Arms & Hands		Muscle Spasms
	Neck feels out of place		Pain upper arm Right Left		HIPS LEGS FEET
	Grinding/popping sound		Pain in elbow Right Left		Pain in buttocks
	TMJ problems		Pain in forearm Right Left		Pain in hip joint Right Left
	Shoulders		Pain in hand Right Left		Pain down Leg Right Left
	Pain in shoulder Right Left		Pain in fingers Right Left		Decreased motion
	Pinched Nerve		Pins & Needles arm Right Left		Pain in knee Right Left
	Can't raise arm		Pins & Needles fingers Right Left		Pain in ankle Right Left
	Decreased Motion		Numbness arm Right Left		Pain in foot Right Left
	Tension in shoulders		Numbness in fingers Right Left		Weakness of leg Right Left
			Weakness of arm Right Left		Weakness of knee Right Left
			Weakness of hand Right Left		Leg cramps Right Left
			Hands Cold		Other:
			Decreased Motion		

I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I certify that the above information is correct to the best of my knowledge. I will no hold my doctor, provider, or any other staff member responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date