Morsch Family Chiropractic

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New Patient Intake Form

Date: _____

Personal Information

Patient's Name: _____ Date of Birth: _____

Address: _____ City:_____ State: _____

Zip Code:_____ Email: _____

Home Phone: _____ Is it ok to leave a detailed message? ☐Yes ☐No

Cell: _____ Is it ok to leave a detailed message? ☐Yes ☐No

Work:_____ Is it ok to leave a detailed message? ☐Yes ☐No

Check if you are: ☐ Married/Domestic Partner ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Spouse/Partner: _____ Ages of Children: _____

Employment or School Information

Name and Address of Employer or School: _____

What are the physical requirements of your work or school? _____

_____

Name and Address of Spouse/Partner's Employer or School: _____

Employment/School Status: ☐ Full-Time ☐ Part-Time ☐ Other _____

Information Regarding Minors

If under 18, Parent/Legal Guardian's Name:

_____

Parent/Guardian's signature for consent to treat a minor:

_____

Medical and Emergency Contacts

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Home Phone: _____ Cell: _____

Family Physician: _____ Date of last visit: _____

Address: _____ Physician's phone number: _____

Who may we thank for referring you: _____

Medical History

Height: _____ Weight: _____ ☐ Right – Handed ☐ Left – Handed

Occupation: _____

What brings you in today? _____

When did pain first occur? _____

How and where did it happen? _____

Have you had this problem before? _____

Work Related?

☐ Yes (If yes, do you plan to apply for Worker's Compensation?) _____

☐No

Motor Vehicle Accident Related?

☐ Yes (If yes, will we be submitting to No Fault?) _____

☐ No

Describe the Pain: ☐ Sharp ☐ Pins & Needles ☐ Stiff ☐ Ache ☐ Burning ☐ Throbbing

☐ Other: _____

Does the pain radiate? ☐ Yes ☐ No

If yes, where? _____

When does it hurt most? _____

Does it hurt to cough or sneeze? ☐ Yes ☐ No

On a scale of 1 -10, what is your pain at its BEST: _____ at its WORST: _____

Have you missed time from work? ☐ Yes ☐ No

If yes, when did you work last? _____

Has your employer restricted your work? ☐ Yes ☐ No

If yes, what restrictions? _____

What activities are you unable to do because of your pain?

At work: _____

At home: _____

Have you had any imaging for this condition? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan

☐ Other _____

List all medications: _____

List all Vitamins/Supplements: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, what do you do? _____

Which of the following aggravates your condition?

☐ Sitting Down ☐ Sitting for long periods ☐ Walking ☐ Standing ☐ Standing for long periods ☐ Laying down ☐ Body Movement ☐ Deep Breathing ☐ Sleeping

☐ Specific Movement/Motion(s): _____

☐ Other: _____

Which of the following relieves your condition?

☐ Sitting ☐ Down ☐ Walking ☐ Laying Down ☐ Massage ☐ Heat/Hot Shower ☐ Ice ☐ Sleeping ☐ Exercise ☐ Stretching

☐ Medications: _____

☐ Other: _____

What other professionals have you seen for treatment of this condition? _____

_____

Are you on any blood thinning agents? ☐ Yes ☐ No

Please list any previous surgeries:

1. _____ Date:_____

2. _____ Date: _____

3. _____ Date: _____

Previous/Current Orthopedic Problems:

_____

_____

Past Medical History – Please check all that apply:

General Symptoms: ☐ Recent weight gain/loss ☐ Blurred Vision ☐ Headache ☐ Fainting

☐ Problems with sleep ☐ Nervousness ☐ Fatigue ☐ Dizziness ☐ Recent fever/infection

☐ Other _____

Endocrine: ☐ Diabetes ☐ Parathyroid ☐ Gout ☐ Liver ☐ Thyroid ☐ Pituitary

☐ Other _____

Have you ever been prescribed a steroid medication? ☐ Yes ☐ No Why? _____

HEENT: ☐ Head Injurie ☐ Hearing Problem ☐ Jaw/TMJ Problem ☐ Inability to taste

☐ Eye/Vision Problems ☐ Inability to Smell ☐ Problems Swallowing ☐ Problems with Speech

☐ Other: _____

Cardiovascular: ☐ Rapid Heartbeat ☐ Slow Heartbeat ☐ Blood Pressure Problem ☐ Poor Circulation ☐ Stroke ☐ Heart Attack ☐ Irregular Heart Beat ☐ Varicose Veins ☐ Ankle/Leg Swelling ☐ Other:

_____

Pulmonary: ☐ Asthma ☐ Shortness of Breath ☐ Chronic Bronchitis ☐ COPD

☐ Other: _____

Gastrointestinal: ☐ Ulcers ☐ Hiatal Hernia ☐ Colitis ☐ Gall Bladder Problem ☐ Diverticulitis ☐ IBS ☐ Other:

_____

Genitourinary: ☐ Kidney Stones ☐ Infections ☐ Bloody Urine ☐ Painful Urination ☐ Night-time Urination ☐ Prostate Problem ☐ Testicle Problem ☐Uterine Problem ☐ Ovarian Problem ☐ Other:

_____

Neurology: ☐ Pinched Nerves ☐ Numbness ☐ Restless Legs ☐ Other:_____

Emotional: ☐ Depression ☐ Anxiety ☐ History of Abuse ☐ Other: _____

Skin: ☐ Rashes ☐ Psoriasis ☐ Moles ☐ Hives ☐ Other: _____

Allergy/Immunology: ☐ Seasonal Allergies ☐ Allergies to Medication_____

☐ Latex ☐ Anemia ☐ Cancer _____ ☐ Autoimmune_____

☐ Other: _____

Social History

Number of Cigarettes Daily: Currently: _____ Age Started: _____ Years Since Quitting: _____

Alcohol Consumption: Drinks per week: _____

Caffeine Consumption: Drinks per day: _____ Type of drink: _____

Water Consumption: Cups per day: _____

Substance Abuse: ☐ Currently ☐ In the Past None

Family History

Father – Current Age or Age at Death: _____ ☐ Alive ☐ Deceased

Serious Illnesses/Cause of Death: _____

Mother – Current Age or Age at Death Age: _____ ☐ Alive ☐ Deceased

Serious Illness/Cause of Death: _____

Brothers #_____ Serious Illnesses, if any: _____

Sisters # _____ Serious Illnesses, if any: _____

Any other family member with a similar condition: _____