**Dr. Jamie's Wellness Center**
2309 Starmount Circle
Huntsville, AL 35801
(256) 4347977

# Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

## Patient Information

**Personal Information**

*First Name: _____
Middle Name: _____
*Last Name: _____
*Gender: ○ Female ○ Male
*Date of Birth: _____
Social Security #: ___ __ ____
Height: [▼] Feet [▼] Inches
Weight: _____
Marital Status: [▼]
Spouse's Name: _____
Number of Children: [▼]

Emergency Contact: _____
Relationship: _____
Phone: _____

**Contact Information**

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

*Home Phone: _____
Cell Phone: _____
Work Phone: _____

Country: United States [▼]
Address Line 1: _____
Address Line 2: _____
City: _____
State/Province/Region: [▼]
*Zip/Postal Code: _____

## Complaint Information

*If you have more than one complaint, address your primary complaint in your responses to the questions in this section and select Yes to indicate that you have an additional complaint. The form will populate a secondary question section for you to address your additional complaint. You may address up to four complaints.*

**What is the purpose of your visit?**
[▼]
**What is the reason for this visit?**
[▼]
**Date of scheduled appointment**
_____
**When did this condition begin?**
_____
**How long have you had this condition?**
[▼]
**What caused this condition?**
[▼]
**Where is the discomfort?**

*Select only one area of discomfort for your chief complaint. Add additional areas of discomfort as additional complaints by selecting **Yes** in response to **Do you have an additional complaint?** at the bottom of this section.*

Head
- ☐ Front of head
- ☐ Back of head
- ☐ Right side of head
- ☐ Left side of head

Neck
- ☐ Front of neck
- ☐ Back of neck
- ☐ Right side of neck
- ☐ Left side of neck

Back
- ☐ Right mid back
- ☐ Central mid back

- [ ] Left mid back

- [ ] Right low back
- [ ] Left low back
- [ ] Central low back

Trunk

- [ ] Abdomen
- [ ] Chest
- [ ] Front of ribs
- [ ] Back of ribs
- [ ] Right side of ribs
- [ ] Left side of ribs

Upper Extremity

- [ ] Front of right upper extremity
- [ ] Rear of right upper extremity
- [ ] Front of left upper extremity
- [ ] Rear of left upper extremity

- [ ] Front of right shoulder
- [ ] Rear of right shoulder
- [ ] Front of left shoulder
- [ ] Rear of left shoulder

- [ ] Front of right upper arm
- [ ] Rear of right upper arm
- [ ] Front of left upper arm
- [ ] Rear of left upper arm

- [ ] Front of right elbow
- [ ] Rear of right elbow
- [ ] Front of left elbow
- [ ] Rear of left elbow

- [ ] Front of right wrist
- [ ] Rear of right wrist
- [ ] Front of left wrist
- [ ] Rear of left wrist

- [ ] Front of right hand
- [ ] Rear of right hand
- [ ] Front of left hand
- [ ] Rear of left hand

Lower Extremity

- [ ] Front of right lower leg
- [ ] Rear of right lower leg
- [ ] Front of left lower leg
- [ ] Rear of left lower leg

- [ ] Front of right hip
- [ ] Rear of right hip
- [ ] Front of left hip
- [ ] Rear of left hip

- [ ] Front of right thigh
- [ ] Rear of right thigh
- [ ] Front of left thigh
- [ ] Rear of left thigh
- [ ] Front of right knee
- [ ] Rear of right knee
- [ ] Front of left knee
- [ ] Rear of left knee

- [ ] Front of right leg
- [ ] Rear of right leg
- [ ] Front of left leg
- [ ] Rear of left leg
- [ ] Front of right ankle
- [ ] Rear of right ankle
- [ ] Front of left ankle
- [ ] Rear of left ankle

- [ ] Top of right foot
- [ ] Bottom of right foot
- [ ] Right side of right foot
- [ ] Left side of right foot
- [ ] Top of left foot
- [ ] Bottom of left foot
- [ ] Right side of left foot
- [ ] Left side of left foot

- [ ] OTHER

**Does the discomfort radiate/travel?**

○ Yes ○ No

**Describe the quality of the discomfort. Choose all that apply.**

- [ ] Aching
- [ ] Annoying
- [ ] Burning
- [ ] Deep
- [ ] Diffuse
- [ ] Dull
- [ ] Heavy
- [ ] Intolerable
- [ ] Pulling
- [ ] Sharp
- [ ] Shock-like
- [ ] Shooting
- [ ] Stabbing
- [ ] Stiffness
- [ ] Throbbing
- [ ] Tightness
- [ ] Tingling
- [ ] OTHER

**Describe the onset of the discomfort. Choose only one.**

○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

**Describe the intensity of the discomfort. Choose only one.**

○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

**Rate the severity of your discomfort on a scale of 1-10 where 1 is the least severe and 10 is the most severe.**

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Least severe <----------> Most severe

**How often do you feel this discomfort? Choose only one.**

○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

**How has this complaint changed since the onset?**

○ Improved ○ Stayed the same ○ Worsened

**What activity is most significantly affected by this discomfort?**

▼

**What aggravates this condition? Choose all that apply.**

- ☐ Almost any movement
- ☐ Athletic activity and/or exercise
- ☐ Bathing
- ☐ Bending
- ☐ Caring for family
- ☐ Carrying
- ☐ Changing positions
- ☐ Climbing stairs
- ☐ Computer use
- ☐ Concentrating
- ☐ Cooking
- ☐ Coughing and/or sneezing
- ☐ Daily child or pet care
- ☐ Driving
- ☐ Eating
- ☐ Falling or staying asleep
- ☐ Getting in or out of car
- ☐ Getting out of bed
- ☐ Getting up from lying down
- ☐ Getting up from sitting
- ☐ Grocery shopping
- ☐ Household chores
- ☐ Lifting
- ☐ Looking over shoulder
- ☐ Love life
- ☐ Lying down
- ☐ Pulling
- ☐ Pushing
- ☐ Reaching
- ☐ Reading
- ☐ Repetitive motions
- ☐ Resting
- ☐ Running
- ☐ Self care (dressing, bathing, etc.)
- ☐ Shaving
- ☐ Sitting
- ☐ Squatting
- ☐ Standing
- ☐ Stress
- ☐ Stretching
- ☐ Talking on telephone
- ☐ Turning
- ☐ Twisting
- ☐ Unknown
- ☐ Walking
- ☐ Working
- ☐ Yard work
- ☐ OTHER

**What improves this condition? Choose all that apply.**

- ☐ Nothing
- ☐ Chiropractic adjustment
- ☐ Cold packs
- ☐ Exercise
- ☐ Heat packs
- ☐ Massage
- ☐ Over-the-counter medications
- ☐ Physical therapy
- ☐ Prescription medication
- ☐ Re-direct attention
- ☐ Rest
- ☐ Stretching
- ☐ Work
- ☐ OTHER

**What treatment have you received for this condition up to now?**

- ☐ None
- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Craniosacral therapy
- ☐ Homeopathic medicine
- ☐ Hypnosis
- ☐ Injection therapy
- ☐ Medical care
- ☐ Naturopathic medicine
- ☐ Nutritional supplements
- ☐ Occupational therapy
- ☐ Osteopathic medicine
- ☐ Over-the-counter medications
- ☐ Physical therapy
- ☐ Prescribed medications
- ☐ Psychotherapy
- ☐ Reiki
- ☐ Surgery
- ☐ OTHER

**Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)?**

○ Yes ○ No ○ Unsure

**Have you ever had any previous episodes of this condition?**

○ Yes ○ No

**In what ways does this condition affect your life and your ability to function? Choose all that apply.**

- ☐ Bending over
- ☐ Caring for family
- ☐ Climbing stairs
- ☐ Concentrating
- ☐ Dressing myself
- ☐ Driving a car
- ☐ Exercising
- ☐ Getting in/out of car
- ☐ Getting to sleep
- ☐ Grocery shopping
- ☐ Household chores
- ☐ Lifting objects
- ☐ Looking over shoulder
- ☐ Love life
- ☐ Lying down
- ☐ Reaching overhead
- ☐ Rising out of chair or bed
- ☐ Showering or bathing
- ☐ Sitting
- ☐ Standing
- ☐ Staying asleep
- ☐ Using a computer
- ☐ Walking
- ☐ Yard work

**Do you have an additional complaint?**

○ Yes ○ No

## Review of Systems

**Musculoskeletal**

☐ No additional musculoskeletal complaints ☐ Additional musculoskeletal complaints

**Neurological**

☐ No additional neurological complaints ☐ Additional neurological complaints

**Head, Eyes, Ears, Nose and Throat**

☐ No complaints ☐ Head, eyes, ears, nose and throat complaints

**Cardiovascular**

☐ No cardiovascular complaints ☐ Heart or blood vessel complaints

**Respiratory**

☐ No respiratory complaints ☐ Breathing or lung complaints

**Gastrointestinal**

☐ No gastrointestinal complaints ☐ Stomach or intestinal complaints

**Genitourinary**

☐ No genitourinary complaints ☐ Genital or bladder or urinary complaints

**Endocrine**

☐ No endocrine complaints ☐ Hormonal or glandular concerns

**Dermatological and Bleeding**

☐ No skin or bleeding complaints ☐ Skin or bleeding concerns

## Past, Family and Social History

**List your (or the patient's) past surgical history. Choose all that apply and indicate the year in which the surgeries were performed.**

☐ Yes, surgical history

☐ No surgical history

**Describe any past illnesses or conditions the doctor should be aware of and the age at which the illness(es) reportedly occurred. Respond respectively to each illness listed. If personal health history is good, select "No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)"**

☐ Yes, past illnesses

☐ No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)

Number of children: ____

Number of pregnancies: ____

Number of deliveries ____

**List any past history of accidents or trauma. Choose all that apply.**

☐ No previous trauma reported
☐ No new trauma reported since initial intake
☐ Single automobile accident
☐ Multiple automobile accidents
☐ Slip and fall
☐ Multiple slip and falls
☐ Single motorcycle accident
☐ Multiple motorcycles accident
☐ Single boating accident
☐ Multiple boating accidents
☐ Resulting in fracture(s)
☐ Resulting in permanent injury or disability
☐ Resulting in hospitalization(s)
☐ Resulting in no significant injury or loss
☐ Resulting in sprains/strains
☐ Resulting in loss of consciousness
☐ Suicide (including attempts)
☐ OTHER

**Are you presently taking any medication?**

○ Yes ○ No

**List your (or the patient's) family health history. Choose all that apply to blood relatives only.**

☐ No family history of diabetes, cancer, hypertension and progressive neurological disorders.

☐ Not applicable, patient was adopted
☐ Unknown
☐ No change in family health history
☐ Extremity issues
☐ Fracture
☐ Heart disease

- [ ] AIDS/HIV
- [ ] Alcoholism
- [ ] Alzheimer's
- [ ] Anemia
- [ ] Anorexia
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding disorders
- [ ] Breast lump
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Chemical dependency
- [ ] Congenital anomaly
- [ ] Depression
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Hepatitis
- [ ] Hereditary disorder
- [ ] Hernia
- [ ] Herniated disc
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Hospitalization
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Migraine headaches
- [ ] Miscarriage
- [ ] Multiple sclerosis
- [ ] Natural labor
- [ ] Neuromuscular issues
- [ ] Osteoarthritis
- [ ] Trauma/injury
- [ ] OTHER

**What are your (or are the patient's) current work habits? Choose all that apply.**

- [ ] None reported
- [ ] No change in work habits since condition began
- [ ] Cannot not work due to presenting condition
- [ ] Permanently fully disabled
- [ ] Permanently partially disabled

- [ ] Full-time
- [ ] Part-time
- [ ] Homemaker
- [ ] Retired
- [ ] Student
- [ ] Unemployed

- [ ] 0 to 20 hours per week
- [ ] 20 to 40 hours per week
- [ ] 40 to 50 hours per week
- [ ] 50 to 60 hours per week
- [ ] 60 to 70 hours per week
- [ ] Over 70 hours per week

- [ ] Mostly sitting
- [ ] Mostly standing
- [ ] Mostly walking
- [ ] Light labor
- [ ] Moderate labor
- [ ] Heavy labor
- [ ] Sedentary
- [ ] Computer
- [ ] Repetitive
- [ ] Telephone
- [ ] Difficult
- [ ] Enjoyable
- [ ] Relaxed
- [ ] Stressful

**How would you describe your (or the patient's) personal social habits? Choose all that apply.**

- [ ] No change in social habits since injury
- [ ] Does not smoke, drink alcohol or take recreational drugs
- [ ] A social drinker

- [ ] Current every day smoker
- [ ] Current some day smoker
- [ ] Ex-smoker
- [ ] Heavy tobacco smoker
- [ ] Light tobacco smoker
- [ ] Never smoked tobacco
- [ ] Smoker, current status unknown
- [ ] Unknown if ever smoked

- [ ] A light drinker
- [ ] A moderate drinker
- [ ] A heavy drinker
- [ ] An alcoholic
- [ ] A recovering alcoholic

- [ ] Does not drink caffeine
- [ ] Drinks 1 cup of caffeine in the morning
- [ ] Drinks 2 to 4 cups of caffeine per day
- [ ] Drinks 5 or more cups of caffeine per day

- [ ] Does not use recreational drugs
- [ ] Light use of recreational drugs
- [ ] Moderate use of recreational drugs
- [ ] Heavy use of recreational drugs
- [ ] Is drug addicted
- [ ] Is A recovering drug addict

**How would you describe your (or the patient's) present exercise habits? Choose all that apply.**

- [ ] No changes in exercise habits since condition began
- [ ] Daily
- [ ] None
- [ ] Every other day
- [ ] Few times a week
- [ ] Once a week
- [ ] Almost nothing
- [ ] Mountain climbing
- [ ] Ping-Pong
- [ ] Racquetball
- [ ] Running
- [ ] Skiing
- [ ] Skydiving

- [ ] Aerobic
- [ ] Stretching
- [ ] Strength
- [ ] Baseball
- [ ] Basketball
- [ ] Blading
- [ ] Boating
- [ ] Climbing
- [ ] Cycling
- [ ] Football
- [ ] Golf
- [ ] Handball
- [ ] Hang gliding
- [ ] Hiking
- [ ] Ice skating
- [ ] Snowboarding
- [ ] Soccer
- [ ] Surfing
- [ ] Tennis
- [ ] Volleyball
- [ ] Walking
- [ ] Waterskiing
- [ ] Weight training
- [ ] Weight training with a personal trainer
- [ ] Pilates
- [ ] Spinning
- [ ] Step
- [ ] Yoga
- [ ] Zumba
- [ ] OTHER

**How would you describe your (or the patient's) diet and nutritional status? Choose all that apply.**

- [ ] No changes in diet or nutrition since condition began
- [ ] Controlled
- [ ] Out-of-control
- [ ] Restricted
- [ ] Unrestricted
- [ ] 1 to 2 meals a day
- [ ] 2 to 3 meals a day
- [ ] More than 3 meals a day
- [ ] Reports eating too little
- [ ] Reports eating too much
- [ ] Binges
- [ ] Purges
- [ ] Balanced
- [ ] High protein
- [ ] Low carbohydrate
- [ ] Low-fat
- [ ] Low-cholesterol
- [ ] No red meat
- [ ] Atkins
- [ ] Diabetic
- [ ] Gluten free
- [ ] Ideal Protein
- [ ] Jenny Craig
- [ ] Kosher
- [ ] Macrobiotic
- [ ] Paleo
- [ ] Raw food
- [ ] South Beach
- [ ] Vegan
- [ ] Vegetarian
- [ ] Weight Watchers
- [ ] Zone
- [ ] Does not take daily supplements
- [ ] Takes daily supplements
- [ ] OTHER

## For Men Only

**COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A MAN OVER 16 YEARS OF AGE.**

**Do you have pain or lump in scrotum or testicles?**

○ Yes ○ No ○ Not Sure

**Do you have impaired libido (sex drive)?**

○ Yes ○ No ○ Not Sure

**Do you have discharge from your penis?**

○ Yes ○ No ○ Not Sure

**Do you have prostate problems?**

○ Yes ○ No ○ Not Sure

**Estimate the date of your most recent prostate exam:**

Approximate Date: _____ ☐ Never had one

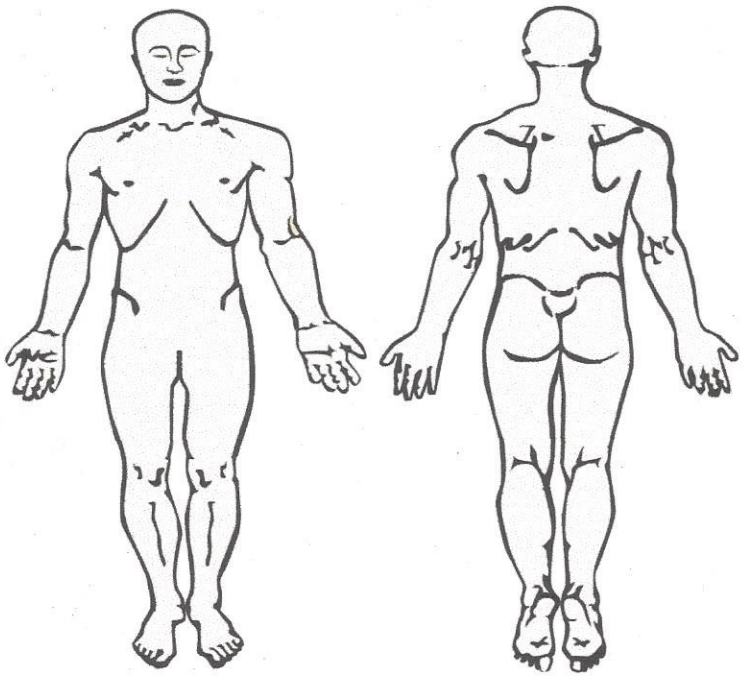
**Estimate the date of your most recent PSA (Prostate-Specific Antigen) test:**

Approximate Date: _____ ☐ Never had one

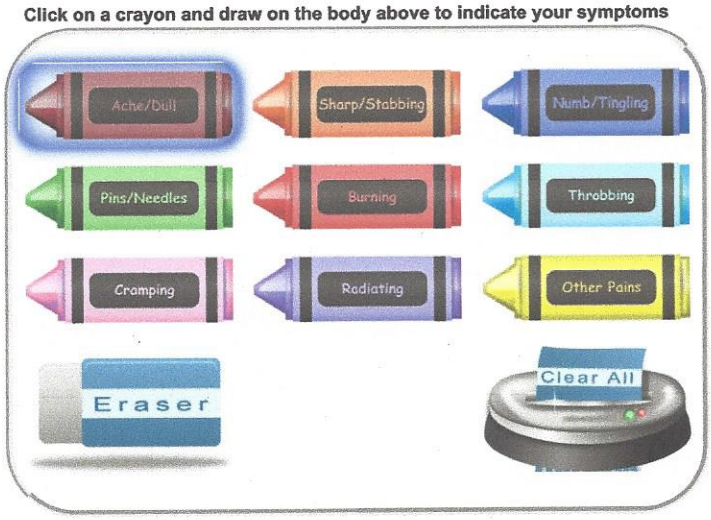
**What was your PSA (Prostate-Specific Antigen) level on your latest test?**

▼

## Draw Your Symptoms



**Click on a crayon and draw on the body above to indicate your symptoms**




## How did you find out about our office?

Referring Physician: _____

Referring Patient: _____

Referred by: _____ ▼

**Did you hear about our office from an advertisement?**

○ No ○ Yes

If Yes, Where:

**Did you hear about our office from a phone or professional directory?**

○ No ○ Yes

If Yes, Where:

## Employment Information

Regular Work Status: _____ ▼

Employer Name: _____

Employer Address: _____

Employer City: _____

Employer State: _____ ▼

Employer Zip: _____

Occupation: _____

Supervisor Name: _____

Supervisor Phone/Extension:

Physical Work Duties:

**What is the purpose of your visit?**

○ Wellness ○ Complaint ○ Injury ○ Other

## Social History & Life Choices:

**Alcohol**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Diet Food Products**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Energy Products or Over-the-Counter Stimulants**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Fresh & Homemade Foods**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Soft Drinks**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Water**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Caffeine Drinks & Products**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Drugs**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Exercise**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Preprocessed, Packaged, & Restaurant Food**

○ Daily ○ Weekly ○ Occasionally ○ Never

**Tobacco**

○ Daily ○ Weekly ○ Occasionally ○ Never

## Chiropractic Experience

**Who referred you to our office?**

**Where did you hear about us?...**

Please select all that apply.

☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing ☐ Other

Other:

_____

**Have you been adjusted by a chiropractor before?**

○ Yes ○ No

**If yes...**

What was the reason for those visits?

Doctor's Name:

_____

Approximate date of last visit:

**Has any member of your family ever seen a wellness chiropractor?**

○ Yes ○ No

## For Women Only

**COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A WOMAN OVER 16 YEARS OF AGE.**

**Are you pregnant?**

○ No ○ Yes

**Are you nursing?**

○ No ○ Yes

**Are you taking birth control?**

○ No ○ Yes

**Do you experience painful periods?**

○ No ○ Yes

**Do you have irregular cycles?**

○ No ○ Yes

**Do you have breast implants?**

○ No ○ Yes

**Do you perform a regular self breast examination?**

○ No ○ Yes

**Do you take hormone replacement therapy (HRT)?**

○ No ○ Yes

**Do you take oral contraceptives?**

○ No ○ Yes

**Estimate the date of your most recent PAP/pelvic exam:**

_____

**Date of last mammogram?**

_____

**Date of Last Menstrual Period?**

_____

## Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ ***I want the Doctor to select the type of care appropriate for my condition.***

☐ **Relief care:** Symptomatic relief of pain or discomfort.

☐ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.

☐ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

## Electronic Health Record (EHR) Information

Preferred Language: ▼ Ethnicity: ▼

Race: ▼

Smoking Status: ▼

Type of Tobacco: ☐ Cigarettes ☐ Chewing Tobacco ☐ Cigar ☐ Pipe ☐ Other

Have you tried to quit? ○ Yes ○ No How much tobacco do you use? _____

How long have you used tobacco? _____

Current Medications And Dosage:

| Medication Name | Dosage |
|---|---|
| | |

Add Another Medication

Medication Allergies:

| Medication Name | Reaction | Date Discovered |
|---|---|---|
| | | |

Add Another Medication Allergies

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

## Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

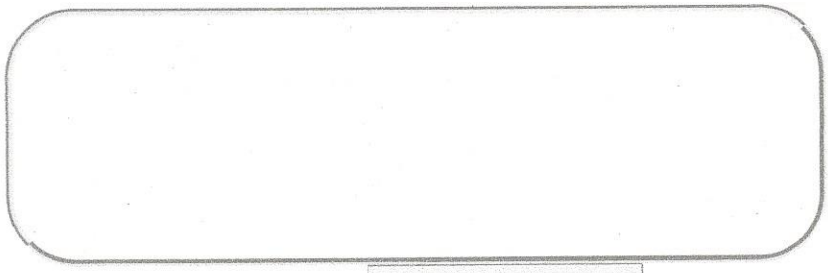
* ☐ **I agree with this statement of authorization**

**Name of the Insured:** _____

(Please Print)

Patient's/Guardian's signature: _____ Date: _____

## Signature



Clear Signature