Integrative Wellness of Charleston

Get Well • Stay Well

NEW PATIENT INTAKE FORM

PATIENT DATA

Date: _____ / _____ / _____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Email: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Social Security Number: _____-_____-_____ Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

SPOUSE DATA

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Employer Data: _____

Name: _____

Your Occupation: _____ Your Job Description: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____

Contact Name: _____ Relationship to Patient: _____

Contact Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Doctor's Signature: _____

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date: _____ / _____ / _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _____			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other _____			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____

Social History: (Check all that apply to you)

Caffeine use:	☐ Occasional	☐ Often	☐ Never
Drink Alcohol:	☐ Occasional	☐ Often	☐ Never
Exercise:	☐ Occasional	☐ Often	☐ Never
Chew Tobacco:	☐ Occasional	☐ Often	☐ Never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ Never
Wear Seat Belts:	☐ Occasional	☐ Often	☐ Never

Other _____

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid :	☐ Parent	☐ Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper
☐ Other _____			

Doctor's Signature: _____

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date: _____ / _____ / _____

Review of Systems: Check box if you have had trouble with any of the following, circle NO if none.

CARDIOVASCULAR	PAST	PRESENT	NO
Poor Circulation			
Hypertension			
Aortic Aneurysm			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of legs			

NEUROLOGIC	PAST	PRESENT	NO
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's			
Carpal Tunnel			
Vertigo			

MUSCULOSKELETAL	PAST	PRESENT	NO
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

GASTROINTESTINAL	PAST	PRESENT	NO
Gall Bladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Doctor's Signature: _____

Integrative Wellness of Charleston

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date: _____ / _____ / _____

Review of Systems: Check box if you have had trouble with any of the following, circle NO if none

EAR, NOSE & THROAT	PAST	PRESENT	NO
Difficulty Swallowing			
Dizziness			
Hearing Loss			
Sore Throat			
Nosebleeds			
Bleeding Gums			
Sinus Infections			

RESPIRATORY	PAST	PRESENT	NO
Asthma			
Tuberculosis			
Short Breath			
Emphysema			
Cold/Flu			
Cough			
Wheezing			

ENDOCRINE	PAST	PRESENT	NO
Thyroid			
Diabetes			
Hair Loss			
Menopausal			
Menstrual			

ALLERGIC/IMMUNOLOGIC	PAST	PRESENT	NO
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

HEMATOLOGIC	PAST	PRESENT	NO
Hepatitis			
Blood Clots			
Cancer			
Bruising			
Fever, Chills			
Sweating			

GENITOURINARY	PAST	PRESENT	NO
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stones			
Lower Side Pain			

Doctor's Signature: _____

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date: _____ / _____ / _____

Review of Systems: Check box if you have had trouble with any of the following, circle NO if none.

PSYCHIATRIC	PAST	PRESENT	NO
Depression			
Anxiety			
Stress			

CONSTITUTIONAL	PAST	PRESENT	NO
Weight Loss/Gain			
Low Energy Level			
Difficulty Sleeping			

EYES	PAST	PRESENT	NO
Glaucoma			
Double Vision			
Blurred Vision			

Please list all current medications being taken: _____

_____

_____

_____

_____

_____

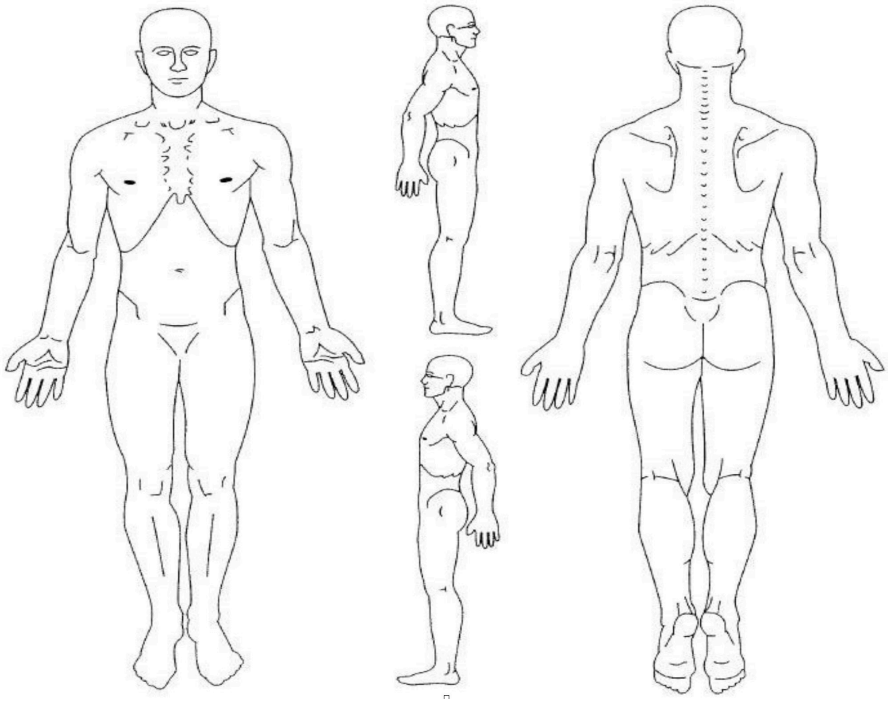
Are you pregnant? ☐Yes ☐ No ☐ N/A

Doctor's Signature: _____

Integrative Wellness of Charleston
Get Well • Stay Well

NEW PATIENT INTAKE FORM

Patient Name: _____ Date: _____ / _____ / _____



By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness

B = Burning

S = Stabbing

T = Tingling

A = Dull Ache

Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month: _____ Day: _____ Year: _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)	☐ Frequently (51-75% of the day)	☐ Occasionally (26-50% of the day)	☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp	☐ Dull ache	☐ Numb	☐ Shooting
☐ Burning	☐ Tingling	☐ Stabbing	☐ Other _____

How are your symptoms changing?

☐ Getting better	☐ Not changing	☐ Getting worse

Doctor's Signature: _____

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EMPLOYMENT, ADL, AND RECREATION INFORMATION

Patient Name: _____ Date: _____ / _____ / _____

Outcomes Assessment Tool Used: _____ **Score:**_____

Description of Work: _____

Condition's Effect On Job Performance:

☐ No Effect ☐ Mild (painful can do) ☐ Mod (painful limited ability)
☐ Mod/Sev (limited duty) ☐ Sev (no limited duty) ☐ Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Care (Infirm Family):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Change Posn (Sit-Stand):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Pet Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Self Care–Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Self Care–Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Self Care–Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev (Unable to Perform)

Doctor's Signature _____

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EMPLOYMENT, ADL, AND RECREATION INFORMATION

Patient Name: _____ Date: _____ / _____ / _____

PAYMENT/INSURANCE INFORMATION

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other _____

Personal Health Insurance Carrier: _____
Policy Holder's Name: _____

Policy Holder's Date of Birth _____ / _____ / _____

Insurance Card ID # _____
Group # _____

Primary Care Physician _____

WORKER'S COMPENSATION INJURY / AUTO / PERSONAL INJURY

Have you filed an injury report with your employer? ☐ Yes ☐ No
Date: _____ / _____ / _____ Time: _____am / pm

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date: _____ / _____ / _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date: _____ / _____ / _____

Doctor's Signature _____