



### New Patient Intake Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender M F

Marital Status: Single Married Wid. Div. Spouse's Name \_\_\_\_\_

Emergency Contact Name/Relation \_\_\_\_\_ Phone #: \_\_\_\_\_

How many children? \_\_\_\_\_ Names & Ages: \_\_\_\_\_

Employer: \_\_\_\_\_

Who is your primary doctor? \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you find out about Enhanced Health Chiropractic?

- Referred by: \_\_\_\_\_  DSM Register  Health Talk
- Community Greetings Visit  Chamber of Commerce (WDM, Waukee, or Clive)
- Other: \_\_\_\_\_

Are you here because you were involved in a:

Motor Vehicle Collision  Work Place Injury  Accident at home  None of these

Are you planning to use health insurance to supplement payment to our office? Y N

Type of insurance:

Health plan (employee or personal)  Health Savings Account  Medicare  Personal Injury

\_\_\_\_\_  
Primary Ins. Company Primary Ins. ID# Primary Ins. Group #

\_\_\_\_\_  
Secondary Ins. Company Secondary Ins. ID# Secondary Ins. Group #

**Insured's Information**  Patient is the insured

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
Street City State Zip

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender M F Employer: \_\_\_\_\_

Relationship to patient:  Self  Spouse  Dependent  Other: \_\_\_\_\_



### Health History

Please describe what brought you into the office today \_\_\_\_\_

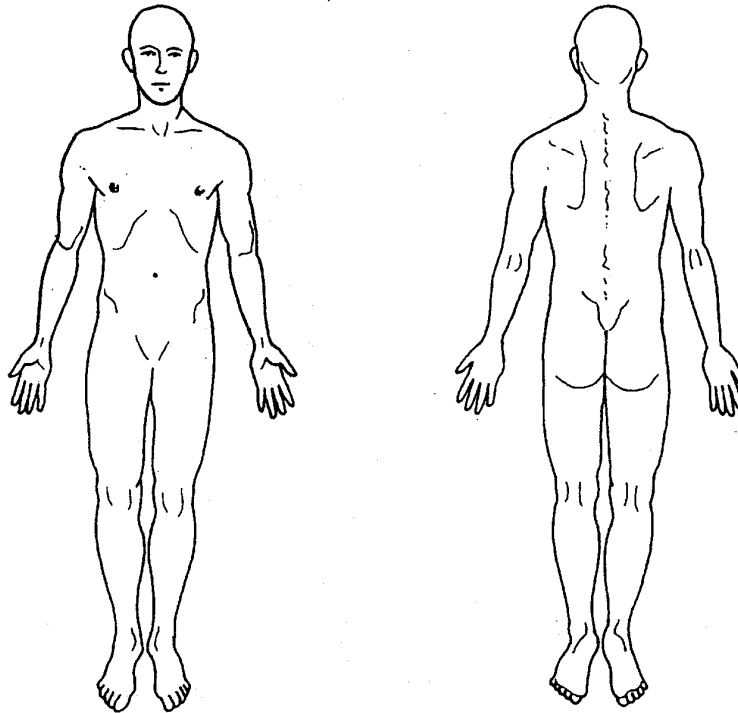
\_\_\_\_\_  
\_\_\_\_\_

On a scale of 1-10, 1 being "No pain or discomfort," 6 being "Pain that limits my work schedule," and 10 being "Pain that causes thoughts of suicide" how would you rate your pain:

NOW: \_\_\_\_ /10    At its WORST: \_\_\_\_ /10    At its BEST: \_\_\_\_ /10    AVERAGE: \_\_\_\_ /10

On the following picture, please mark the areas on your body where you feel pain or other issues. Please use the key below to describe the type of pain.

**A** - Ache    **B** - Burning    **N** - Numbness    **S** - Stabbing    **T** - Throbbing    **P** - Pins & Needles



If you have no pain please check here: \_\_\_\_\_

What needs to happen for you to consider your treatment plan a success? \_\_\_\_\_

\_\_\_\_\_

Have you ever consulted a Chiropractor before?    Y    N    If yes, who? \_\_\_\_\_

When? \_\_\_\_\_ Why? \_\_\_\_\_ For how long? \_\_\_\_\_

When was the last time any of the following tests were ordered, and by whom?

X-rays? \_\_\_\_\_ MRI? \_\_\_\_\_ Blood panel? \_\_\_\_\_ Other? \_\_\_\_\_



**Do you now, or have you ever suffered from:** (please mark "N" for now or "P" for past)

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Neck Pain  | <input type="checkbox"/> Low Back Pain    | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Dizziness                 |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Lung problems    | <input type="checkbox"/> Neuritis         | <input type="checkbox"/> High Cholesterol          |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Disorder    | <input type="checkbox"/> Irritability     | <input type="checkbox"/> Menstrual Pain/Difficulty |
| <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Heart trouble    | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Sinus trouble             |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Digestive disorder        |
| <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Tumor            | <input type="checkbox"/> Numbness in Hands/Feet    |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Tire Easily      | <input type="checkbox"/> TB               | <input type="checkbox"/> Tingling in Hands/Feet    |

Please list any other health concerns you have at this time: \_\_\_\_\_

Has anybody in your immediate family (last two generations) had any of the following conditions, either currently or previously? Please indicate relationship.

- |  |                                  |   |   |
|--|----------------------------------|---|---|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Stroke  | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Obesity | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Out of Shape   |
| <input type="checkbox"/> Other conditions: _____ |                                  |   |   |

I am interested in the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Decreasing Pain | <input type="checkbox"/> Improving Balance | <input type="checkbox"/> Improving Posture     | <input type="checkbox"/> Increasing Strength      |
| <input type="checkbox"/> Changing Weight | <input type="checkbox"/> Improving Diet    | <input type="checkbox"/> Improving Flexibility | <input type="checkbox"/> Improving Overall Health |

List ALL past accidents/injuries: (include date of injury)

Vehicle Accidents: \_\_\_\_\_

Sports Injuries: \_\_\_\_\_

Childhood Injuries: \_\_\_\_\_

Broken Bones: \_\_\_\_\_

Other: \_\_\_\_\_

Have you had any of the following surgeries/procedures: (please indicate year)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Back/Spine                 | <input type="checkbox"/> Neck          | <input type="checkbox"/> Tonsillectomy       | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Gallbladder                | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Appendectomy        | <input type="checkbox"/> Stomach       |
| <input type="checkbox"/> Spinal injection           | <input type="checkbox"/> Tubes in ears | <input type="checkbox"/> Female/Male surgery | <input type="checkbox"/> No Surgeries  |
| <input type="checkbox"/> Any Other Surgeries: _____ |  |  |  |

Any Other Medical Procedures: \_\_\_\_\_



**Activities of Daily Living:**

Please describe the type of work you do on a daily basis: \_\_\_\_\_

\_\_\_\_\_

Do you use tobacco? Y N Have you ever? Y N How many packs per day? \_\_\_\_\_

How many servings of pop do you drink per day? \_\_ 0 \_\_ 1-2 \_\_ 3-4 \_\_ >5

How many servings of coffee do you drink per day? \_\_ 0 \_\_ 1-2 \_\_ 3-4 \_\_ >5

How many servings of alcohol do you drink per day? \_\_ 0 \_\_ 1-2 \_\_ 3-4 \_\_ >5

How many glasses of water do you drink per day? \_\_ 0 \_\_ 1-2 \_\_ 3-4 \_\_ >5

How many hours per day do you spend: Driving: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5

TV: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5 Computer: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5

How many servings of each of the following foods do you eat per day?

Veggies: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5 Meat: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5

Fruits: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5 Dairy: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5

Carbs: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5 Sweets: \_\_ <1 \_\_ 1-3 \_\_ 3-5 \_\_ >5  
(Breads & Pastas)

Do you drink diet sodas or eat sugar-free food? Y N

Do you take any drugs, supplements or vitamins? Y N

If Yes, please fill out Drug & Supplement Record

Do you exercise? Y N How long do your workouts last? \_\_\_\_\_

How often do you exercise? \_\_ >=5x/week \_\_ 3-4x/week \_\_ 1-2x/week \_\_ <1x/week

What do you do while exercising? (mark all that apply)

- Running
- Swimming
- Abs
- Stretching/flexibility
- Walking
- Yoga/Pilates
- Weight lifting
- Resistance bands
- Stairs
- Group classes
- Rock Climbing
- Other: \_\_\_\_\_

For Women Only:

Are you currently pregnant? Y N Unsure Date last period began: \_\_\_\_\_

Do any of the following pertain to you?

Tubal ligation  Hysterectomy (comp/partial)  Birth Control Pills  Partner vasectomy

Thank you for taking the time to completely fill out this paperwork. Dr. Tom will review your information and then begin your consultation. If you have any questions while completing these forms please ask.

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