ALPINE
CHIROPRACTIC & ACUPUNCTURE

Patient Intake Form Date:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. (check one)

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

Address:_____

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 ☐ Full Time Student ☐ Part Time Student ☐ Other (check one)

Spouse Data

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

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

Employer Data

☐ Retired ☐ Not Applicable

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact

Contact Name:_____ Contact Phone: ( ) _____-_____

Relationship: _____

ALPINE
CHIROPRACTIC & ACUPUNCTURE

Review of Systems Form

Patient Name:_____ Date: _____

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

Review of Systems: Please check "Yes" or "No" as they relate to your health.

CONSTITUTIONAL

Weight Loss	☐ Y	☐ N
Fever	☐ Y	☐ N
Fatigue	☐ Y	☐ N
Changing Appetite	☐ Y	☐ N

EAR/NOSE/THROAT

Vertigo	☐ Y	☐ N
Sinus Infections	☐ Y	☐ N
Hoarseness	☐ Y	☐ N
Frequent Nosebleeds	☐ Y	☐ N

GENITOURINARY

Pain Urinating	☐ Y	☐ N
Kidney Stone	☐ Y	☐ N
Frequent Urination	☐ Y	☐ N
Kidney Disease	☐ Y	☐ N
Blood in Urine	☐ Y	☐ N

RESPITORY

Shortness of Breath	☐ Y	☐ N
Coughing Blood	☐ Y	☐ N
Asthma	☐ Y	☐ N
Persistent Cough	☐ Y	☐ N
Frequent Infection	☐ Y	☐ N

GASTROINTESTINAL

Abdominal Pain	☐ Y	☐ N
Nausea/Vomiting	☐ Y	☐ N
Heartburn	☐ Y	☐ N
Hepatitis	☐ Y	☐ N
Bloody/Black Stool	☐ Y	☐ N
Appendicitis	☐ Y	☐ N
Gall Bladder Problems	☐ Y	☐ N

CARDIOVASCULAR

Chest Pain	☐ Y	☐ N
Pacemaker	☐ Y	☐ N
Palpitations	☐ Y	☐ N
Swelling of Extremities	☐ Y	☐ N
Shortness of Breath	☐ Y	☐ N
Poor Circulation	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N
Aortic Aneurism	☐ Y	☐ N
High Cholesterol	☐ Y	☐ N

HEMATOLOGIC

Easy Bruising	☐ Y	☐ N
Gums Bleed Easily	☐ Y	☐ N
Blood Clots	☐ Y	☐ N
Prolonged Bleeding	☐ Y	☐ N
Cancer	☐ Y	☐ N

MUSCULOSKELETAL

Joint Pain/Swelling	☐ Y	☐ N
Stiffness	☐ Y	☐ N
Muscle Pain	☐ Y	☐ N
Back Pain	☐ Y	☐ N
Herniated Disc	☐ Y	☐ N
Pinched Nerve	☐ Y	☐ N
Gout	☐ Y	☐ N
Osteoporosis	☐ Y	☐ N
Rheumatoid Arthritis	☐ Y	☐ N
Multiple Sclerosis	☐ Y	☐ N

NEUROLOGIC

Stroke	☐ Y	☐ N
Seizures	☐ Y	☐ N
Brain Aneurysm	☐ Y	☐ N
Parkinson's Disease	☐ Y	☐ N
Neuropathy	☐ Y	☐ N

OTHER

Diabetes	☐ Y	☐ N
Thyroid Disease	☐ Y	☐ N
Glaucoma	☐ Y	☐ N
Prostate Problems	☐ Y	☐ N
HIV/AIDS	☐ Y	☐ N
Scarlet Fever	☐ Y	☐ N

ALPINE
CHIROPRACTIC & ACUPUNCTURE

Past Family History: Please complete the following table.

NAME	AGE (if Alive)	HEALTH PROBLEM	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Siblings				
Grandparents				

Past Surgical History: Please list below all your past operations with reason and date.

OPERATION **DATE**

Please List All Current Medication (Including Vitamins/Herbs/Minerals)

Do you have any allergies? ☐ **Y** ☐ **N** **List:** _____

Do you have a Primary Care Physician (Family Doctor)? _____

Date of last Physical Exam? _____ **Last Spinal X-Ray/MRI/CT** _____

Social History:

☐ **Y** ☐ **N** **Do you Smoke:** **# packs / day** _____ **# years smoked:** _____

☐ **Y** ☐ **N** **Do you drink alcohol? If Yes, please list type and quantity:** _____

☐ **Y** ☐ **N** **Do you exercise? Type** _____ **Miles** _____ **Times /Days per Week** _____

Work Activity: ☐ **Sitting** ☐ **Standing** ☐ **Light Labor** ☐ **Heavy Labor**

Current Occupation: _____

Patient Name: _____ Initials: _____

ALPINE
CHIROPRACTIC & ACUPUNCTURE

Reason for your Visit: _____

When did your symptoms appear? _____

How did your symptoms appear? _____

How often do you experience your symptoms?

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

Are your symptoms getting progressively worse? ☐ Yes ☐ No ☐ Unsure

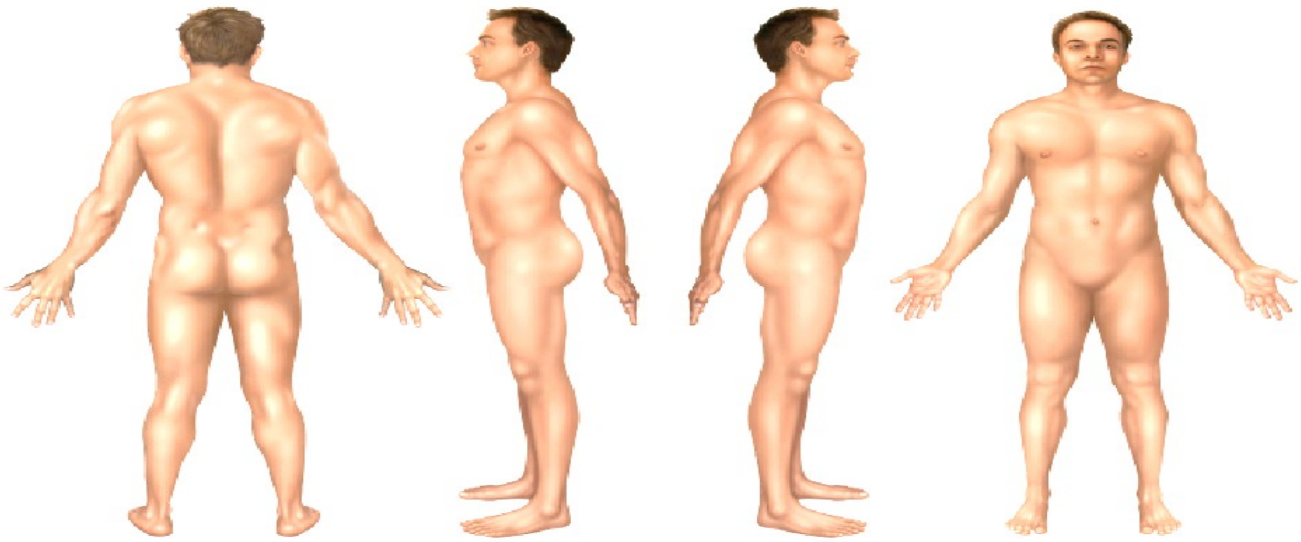
Does the pain interfere with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Does not interfere

PAIN DRAWING

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain and include all affected areas. You may draw in the face as well.

Numbness = 0 Dull Ache = X Burning = + Stabbing = V Pins & Needles = /



Please mark on the line the pain level that most accurately represents your pain:

0= No Pain 10= Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Have you received treatment for your condition previously? ☐ Y ☐ N

If Yes: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic

Name and Address of Provider that treated you for your condition _____

Patient Name: _____ Initials: _____