Patient Information

Thank you for choosing Elite Chiropractic Health Center for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(Please print clearly)

Name:____ SS #:____________________________

First Middle Initial Last

Address:____________________________________City:__________________State:________Zip:__________

Sex: ☐Female ☐Male Birthday:____________________Email:______________________________________

Home Phone: (___)____________________Cell Phone: (___)________________Work Phone: (___)______________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____years

Patient Employer/School:______________________________________ Occupation:____________________

Employer/School Address:________________________________City:________________State:______Zip:__________

Spouse/parent's name:______________________________Employer:______________Work Phone: (___)__________

Whom may we thank for referring you to us?____

Person to contact in case of emergency:____________________________________Phone: (___) ______________

Responsible Party

Name of person responsible for this account:____

Relationship to the patient:____Phone (___) ____________________

Address:____________________________________City:__________________State:________Zip:__________

Name of employer:____Work Phone: (___)__________________

Insurance Information

Name of insured:_________________________________Relationship to patient:___________________________

Birthdate:________________________Social Security #:____________________Date employed:________________

Name of employer:____Work Phone: (___)__________________

Address:____________________________________City:__________________State:________Zip:__________

Insurance Co.:______________________Phone: (___)______________Group #:____________Employer #:__________

Insurance Co Address:__________________________City:__________________State:________Zip:__________

How much is your deductable?____________ How much have you used?____________ Max. annual benefit?____________

Do you have additional insurance? ☐ Yes ☐No If yes, please complete the following:

Name of insured:_____________________________________Relationship to patient:_______________________

Birthday:________________________Social Security #:____________________Date employed:________________

Name of employer:______________________________________Work phone: (___)______________________

Address:____________________________________City:__________________State:________Zip:__________

Insurance Co.:______________________Phone: (___)______________Group #:____________Employer #:__________

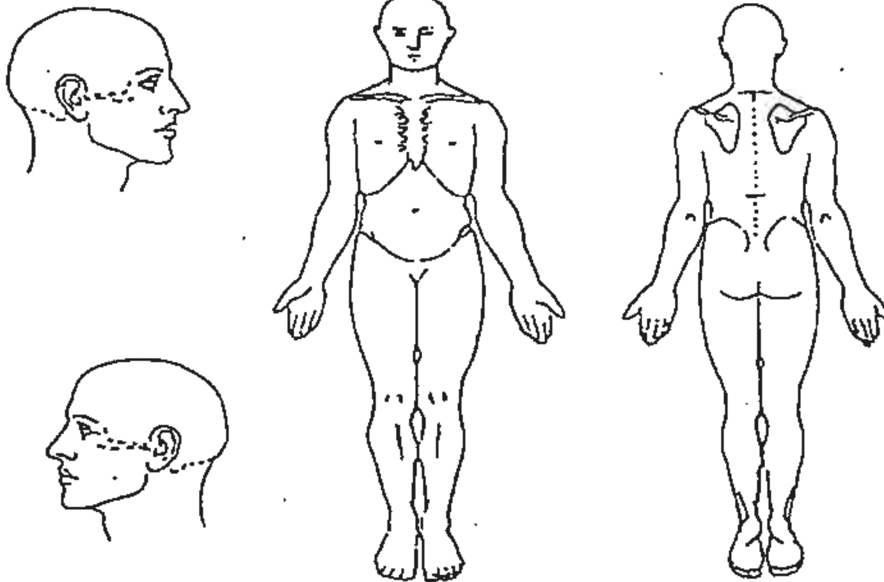
Insurance Co Address:__________________________City:__________________State:________Zip:__________

How much is your deductable?____________ How much have you used?____________ Max. annual benefit?____________

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: ____________________

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation
2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time)
   - ☐ Occasionally (26-50% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Intermittently (1-25% of the time)
4. How would you describe the type of pain?
   - ☐ Sharp ☐ Numb ☐ Dull
   - ☐ Tingly ☐ Diffuse ☐ Sharp with Motion
   - ☐ Achy ☐ Shooting ☐ Shooting with Motion
   - ☐Burning ☐ Stabbing ☐ Stabbing with Motion
   - ☐ Stiff ☐ Electric-like with Motion ☐ Other: ____________
5. How are your symptoms changing with time?
   - ☐ Getting Worse ☐ Staying the Same ☐ Getting Better
6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please Circle)*

7. How much has the problem interfered with your work?
   - ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. How much has the problem interfered with your social activities?
   - ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. Who else have you seen for your problem?
   - ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
   - ☐ ER Physician ☐ Orthopedist ☐ Message Therapist
   - ☐ Physical Therapist ☐No One ☐ Other: ____________
10. How long have you had this problem? ____________________
11. How do you think your problem began?

    ____

12. Do you consider this problem to be severe?
    - ☐ Yes ☐ Yes, at times ☐ No
13. What aggravates the problem? ________________________________
14. What concerns you the most about your problem; what does it prevent you from doing?

    ____

15. What is your: Height ______________ Weight ________________ Date of Birth________________
Occupation: ____

16. How would you rate your overall health?
❒ Excellent ❒ Very Good ❒ Good ❒Fair ❒ Poor

17. What type of exercise do you do?
❒ Strenuous ❒ Moderate ❒ Light ❒ None

18. Indicate if you have any immediate family members with any of the following:
❒ Rheumatoid Arthritis ❒ Diabetes ❒ Lupus
❒ Heart Problems ❒ Cancer ❒ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
❒	❒ Headaches	❒	❒ High Blood Pressure	❒	❒ Diabetes
❒	❒ Neck Pain	❒	❒ Heart Attack	❒	❒ Excessive Thirst
❒	❒Upper Back Pain	❒	❒ Chest Pain	❒	❒ Frequent Urination
❒	❒Mid Back Pain	❒	❒ Stroke	❒	❒ Smoking/Tobacco Use
❒	❒Low Back Pain	❒	❒ Angina	❒	❒Drug/Alcohol Dependence
❒	❒ Shoulder Pain	❒	❒ Kidney Stones	❒	❒ Allergies
❒	❒ Elbow/Upper Arm Pain	❒	❒ Kidney Disorders	❒	❒ Depression
❒	❒ Wrist Pain	❒	❒ Bladder Infection	❒	❒ Systemic Lupus
❒	❒ Hand Pain	❒	❒ Painful Urination	❒	❒ Epilepsy
❒	❒ Hip Pain	❒	❒ Loss of Bladder Control	❒	❒ Dermatitis/Eczema/Rash
❒	❒ Upper Leg Pain	❒	❒ Prostate Problems	❒	❒ HIV/AIDS
❒	❒ Knee Pain	❒	❒ Abnormal Weight Gain/Loss	❒	❒ Dizziness
❒	❒ Ankle/Foot Pain	❒	❒ Loss of Appetite		
❒	❒ Jaw Pain	❒	❒ Abdominal Pain		
❒	❒ Joint Pain/Stiffness	❒	❒ Ulcer		**FOR FEMALES ONLY**
❒	❒ Arthritis	❒	❒ Hepatitis	❒	❒ Birth Control Pills
❒	❒ Rheumatoid Arthritis	❒	❒ Liver/Gall Bladder Disorder	❒	❒ Hormonal Replacement
❒	❒ Cancer	❒	❒ General Fatigue	❒	❒ Pregnancy
❒	❒ Tumor	❒	❒ Muscular In coordination		
❒	❒ Asthma	❒	❒ Visual Disturbances		
❒	❒ Chronic Sinusitis	❒	❒ Other:__________________		

20. List all prescription medications you are currently taking:
____

21. List all over-the-counter medications you are currently taking:
____

22. List all surgical procedures you have had (and dates):
____

23. What activities do you do at work?
❒ Sit: ☐ Most of the Day ☐ Half the day ☐ A little of the day
❒Stand: ☐ Most of the Day ☐ Half the day ☐ A little of the day
❒ Computer Work: ☐ Most of the Day ☐ Half the day ☐ A little of the day
❒ On the Phone : ☐ Most of the Day ☐ Half the day ☐ A little of the day

24. What activities do you do outside of work?
____

25. Have you ever been hospitalized? ☐ No ☐ Yes

26. Have you had significant past trauma? ☐ No ☐ Yes

27. Anything else pertinent to your visit today? ______________________________

Patient Signature: ____ Date: ____________________

Complaints Form: Elite Chiropractic Center

Name:______________________________ **Date:**________________

A. NECK OR CERVICAL SPINE	**NONE**	**MILD**	**MODERATE**	**SEVERE**
1. Neck Pain and Soreness	A	B	C	D
2. Loss or Pain upon Movement	A	B	C	D
3. Shoulder Pain	A	B	C	D
4. Pain/Numbness/Tingling in arm or hand	A	B	C	D
5. Weakness in arm or Hand	A	B	C	D

B. MID-BACK OR THORACIC SPIN	**NONE**	**MILD**	**MODERATE**	**SEVERE**
1. Mid-Back Pain	A	B	C	D
2. Rib or Chest Pain	A	B	C	D

C. LOWER BACK OR LUMBAR SPINE	**NONE**	**MILD**	**MODERATE**	**SEVERE**
1. Lower Back Pain or Soreness	A	B	C	D
2. Loss of Movement or Pain with Movement	A	B	C	D
3. Pain into Hips or Buttocks	A	B	C	D
4. Pain in Legs, Knees, Feet/or any combination of these	A	B	C	D
5. Numbness/Burning in Legs or Feet	A	B	C	D

D. OTHER COMPLAINTS	**NONE**	**MILD**	**MODERATE**	**SEVERE**
1. Headaches	A	B	C	D
2. Visual Disturbances or Blurry Vision	A	B	C	D
3. Ringing or Buzzing in Ears	A	B	C	D
4. Nausea or Vomiting	A	B	C	D
5. Difficulty Breathing	A	B	C	D
6. Dizziness	A	B	C	D
7. Recent Unexplained Weight Loss	A	B	C	D
8. Bowel or Bladder Dysfunction	A	B	C	D

E. AGGRAVATED BY	**NONE**	**MILD**	**MODERATE**	**SEVERE**
1. Coughing	A	B	C	D
2. Sneezing	A	B	C	D
3. Prolonged Periods of Sitting	A	B	C	D
4. Prolonged Periods of Standing	A	B	C	D
5. Prolonged Periods Sitting in a vehicle	A	B	C	D
6. Lying on Stomach	A	B	C	D