FREEDMAN CHIROPRACTIC CENTER, LLC INITIAL INTAKE FORM – ANSWER ALL QUESTIONS

Today's Date:_____ HRN: _____

Whom may we thank for referring you to this office? → _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____/_____/_____Age: _____ ☐ Male ☐ Female

Address:_____City:_____State:_____Zip: _____

E-mail Address:_____Home Phone:_____Mobile Phone:_____

Mobile Carrier:_____ Do you authorize this office to send: Emails ❑ Yes ❑ No Text Reminders ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Social Security #:_____Driver's License #: _____

Employer:_____Occupation: _____

Spouse's Name_____Spouse's Employer _____

Children's names and their ages: _____

Emergency Contact and number:_____Relationship: _____

HISTORY of COMPLAINT

Please identify your complaint(s) in their order of importance:

#1:_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ ***On average:*** _____ ***At its best:*** _____ ***At its worst:*** _____ **V.P.N.** _____
(0-10) **(0-10)** **(0-10)** **(0-10)**

#2_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ ***On average:*** _____ ***At its best:*** _____ ***At its worst:*** _____ **V.P.N.** _____
(0-10) **(0-10)** **(0-10)** **(0-10)**

#3_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ ***On average:*** _____ ***At its best:*** _____ ***At its worst:*** _____ **V.P.N.** _____
(0-10) **(0-10)** **(0-10)** **(0-10)**

#4_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ ***On average:*** _____ ***At its best:*** _____ ***At its worst:*** _____ **V.P.N.** _____
(0-10) **(0-10)** **(0-10)** **(0-10)**

What relieves your symptoms? _____

What makes them feel worse? _____

When did the problem(s) begin?_____When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident or injury? ☐ No ☐ Yes, Describe _____

Above condition(s) ever been treated by anyone in the past? ☐No ☐Yes, by whom and when:_____

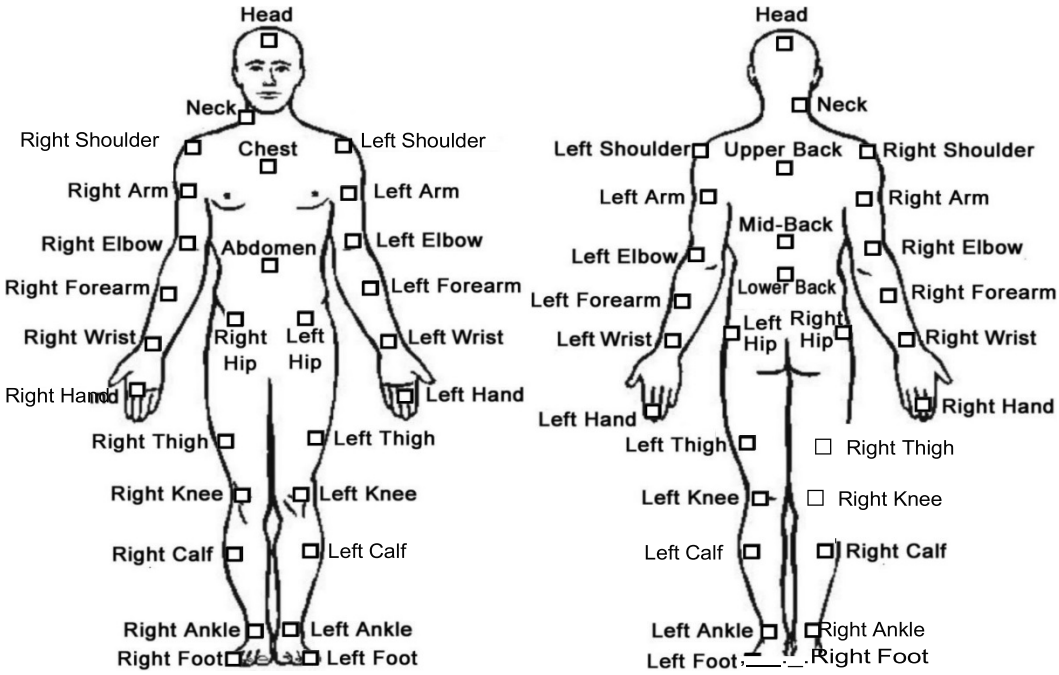
How long were you under care?_____What were the results? _____

Previous Chiropractor? ☐No ☐ Yes, who? _____

Patient's Name: _____ **Date:** _____

PLEASE MARK the areas on the diagram with the following **letters** to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T=** Tingling

Elaborate More:



LIST RESTRICTED ACTIVITY:	AMOUNT YOU CAN PERFORM NOW?	... WITHOUT YOUR COMPLAINT?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem(s):

	HOW LONG AGO	TYPE OFCARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

Please list all of your past jobs where you experienced physical, chemical or emotional stress:

_____

List prescription & over the counter drugs you take:

_____

Patient's Name: _____ **Date:** _____

For **EACH** condition indicate***: C = Currently Have P = in the Past N = Never had:***

___Broken Bone	_____Dislocations	_____Tumors	_____Rheumatoid Arthritis	_____Fracture
___Disability	____Cancer	_____Heart Attack	_____Osteoarthritis	_____Diabetes
___Stroke	_____Headache	_____Pregnant	_____Dizziness	_____Prostate Problems
___Loss of Balance	_____Neck Pain	_____Ulcers	_____Heartburn	_____Frequent Colds/Flu
___Jaw Pain, TMJ	_____Fainting	_____Heart Problem	_____Convulsions/Epilepsy	_____Digestive Problems
___Shoulder Pain	____Tremors	_____Double Vision	_____Colon Trouble	_____High Blood Pressure
___Upper Back Pain	_____Chest Pain	_____Blurred Vision	_____Diarrhea/Constipation	_____Low Blood Pressure
___Mid Back Pain	_____Ringing in Ears	_____Irritable	_____Impotence/Sexual Dysfun.	_____Pain w/Cough/Sneeze
___Low Back Pain	_____Hearing Loss	_____Hip Pain	_____Foot or Knee Problem	_____Difficulty Breathing
___Depression	_____PMS	_____Lung Problems	_____Back Curvature	_____Sinus/Drainage Problem
___Bed Wetting	_____Kidney Trouble	_____Scoliosis	_____Skin Problems	_____Menstrual Problem
___Mood Changes	_____Learning Disability	_____ADD/ADHD	_____Eating Disorder	_____Swollen/Painful Joints
___Liver Trouble	_____Trouble Sleeping	_____Allergies	_____Hepatitis (A B C)	_____Gall Bladder Trouble
___Numbness/Tingling arms, hands, fingers		_____Numbness/Tingling legs, feet, toes		_____Asthma

Other condition(s) not listed: _____

Rate how well you handle emotional stress on a scale from: 0 (Fragile) to 10 (Nothing bothers you): _____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs - - - - - - - - - → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ----------→ ❑ Daily ❑ Weekends ❑ Occasionally ❑Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect your daily life? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes: _____

I hereby authorize Ken Freedman, DC, or the employees of Freedman Chiropractic Center, LLC, to provide services to me or, if applicable, my minor child. I also authorize payment to be made directly to ***Freedman Chiropractic Center, LLC***, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ***Freedman Chiropractic Center, LLC*** for any and all services my minor child / I receive at this office.

_____ _____/_____/ _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____/_____/ _____

Doctor's Signature **Date Form Reviewed**