Precision Chiropractic ATX
Patient Intake Form

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Gender: ____ M ____ F Date of Birth: _____ Social Security #: _____ - ____ - _____

Height: _____ Weight: _____ Marital Status: _____ # of Children _____

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship: _____

EMPLOYMENT INFORMATION

_____ Full Time _____ Part Time _____ Student _____ Retired _____ Unemployed _____ Other

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State: ____ Zip: _____

Physical Work Duties: _____

Have you ever been to a chiropractor? ____ Yes ____ No

If so, who? _____

Purpose of your visit:

____ Wellness ____ Pain ____ Injury ____ Neurological Care ____ Performance Training

CURRENT COMPLAINTS

Due to a car accident? ____ Yes ____ No Due to a work accident? ____ Yes ____ No

Please describe the nature of your current complaint (location, intensity, quality, etc):

_____

_____

_____

_____

When did this start? _____

How did this start? _____

How frequent do you experience this? ____ Always ____ Hourly ____ Daily ____ Occasionally

Does this condition interfere with your daily activities? ____ Yes ____ No

Does this condition affect your sleep? ____ Yes ____ No How? _____

Does this condition affect your appetite? ____ Yes ____ No How? _____

Have you missed work due to this? ____ Yes ____ No How often? _____

Is the condition worse at certain times of the day? ____ Yes ____ No

Explain: _____

Do certain movements or activities make your condition worse? ____ Yes ____ No

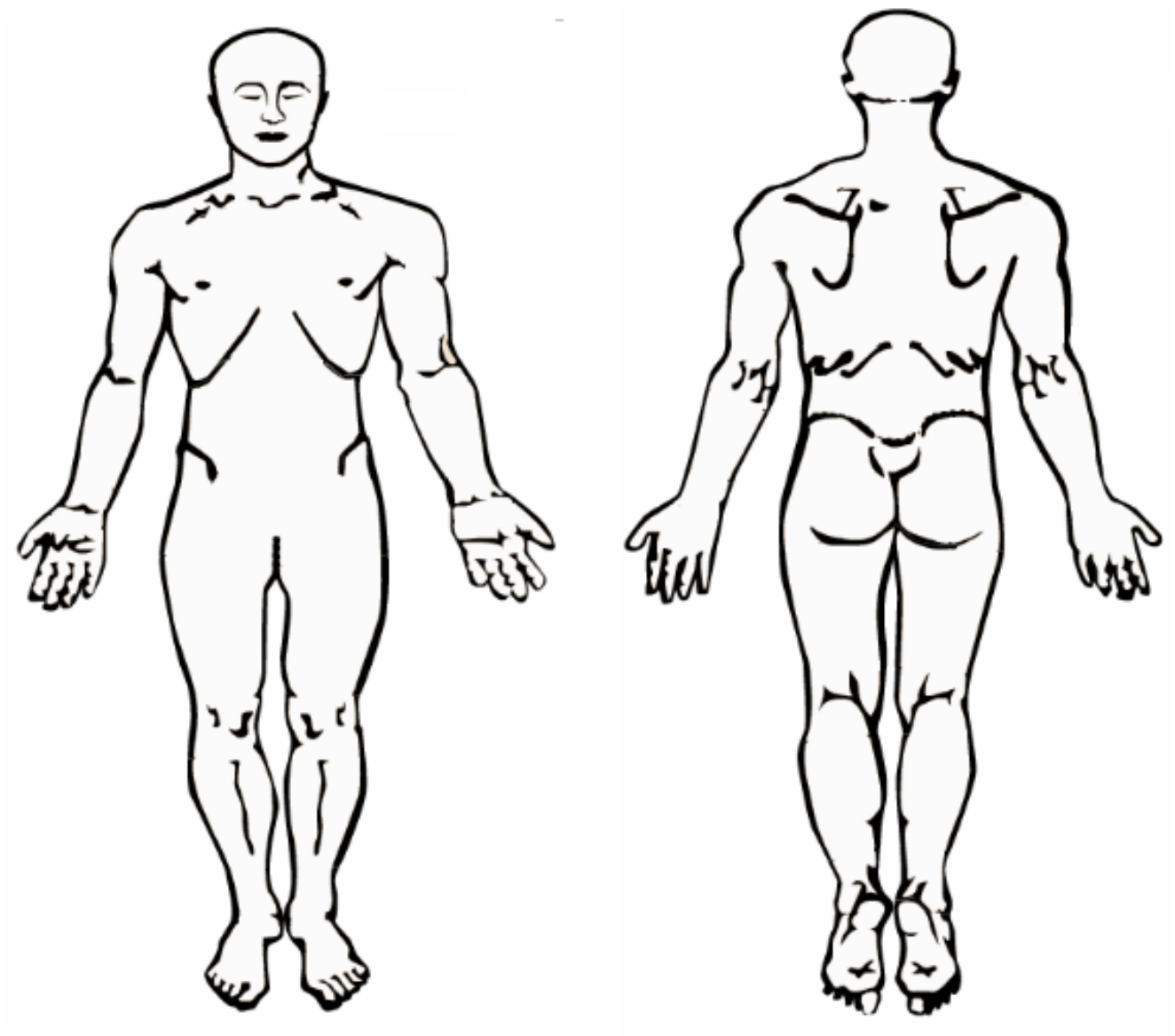
Explain: _____

Have you seen another medical professional for your current complaints? ____ Yes ____ No

If yes, where? _____

Have you ever experienced this condition at a prior time in your life? ____ Yes ____ No
If so, when? _____

Please place letters at areas of pain or discomfort on the diagrams below:



Please rate your pain or discomfort on a scale of 1-10, with 10 being worst:

A _____ B _____ C _____ D _____ E _____ F _____ G _____

H _____ I _____ J _____ K _____ L _____ M _____ N _____

PERSONAL HEALTH HISTORY

Date of Last Physical Exam: _____ Name of Physician: _____

Physician Phone: _____ Physician City: _____ Physician State: ____

Please list conditions you have been treated for in the last 10 years:

_____

_____

Please list any hospitalizations in the last 10 years:

_____

_____

Please list all surgeries or operations:

_____

_____

List Current Medications and Dosages:

_____

_____

List Current Nutritional Supplements (please also include vitamins, minerals, and herbs):

_____

_____

Are you a smoker? ____ Yes ____ No _____ packs per day

How much alcohol do you consume per week? _____ drinks per week

How much exercise (greater than 30 mins) do you get per week? _____ times per week

What type of exercise? _____

Which of the following do you take into consideration the most when making decisions about your healthcare provider?

_____ Cost

_____ Time

_____ Integrity

_____ Results

By signing below I authorize Precision Chiropractic ATX and its staff to use the information provided herein to help make the best decisions for my care. I certify that the information provided is true and accurate to the best of my knowledge. I understand that Precision Chiropractic ATX does not accept insurance, Medicare, or payment from any third party. All payments are the responsibility of the patient and are due at the time of service unless otherwise agreed upon in writing by both Precision Chiropractic ATX and the patient.

_____ _____

Patient/Guardian Date