POWELL
CHIROPRACTIC CLINIC
FUNCTIONAL NEUROLOGY
& FAMILY CHIROPRACTIC CARE

MIKE POWELL, D.C., DACNB
Functional Neurology
KOURTNÉ SHANAHAN, D.C.
Family Chiropractic Care

New Patient Health History Intake

Demographics

Name_____ Date of birth_____

Age_____ Gender_____ What do you prefer to be called? _____

Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Cell Phone_____

Email Address_____ SS#_____

Spouse's name_____

Children's names and ages _____

_____

Employer_____ Occupation_____ Work Phone _____

Emergency Contact_____ Relation_____ Phone_____

How did you hear about our office? _____

May we send you a text message and email appointment reminder? _____

Motor Vehicle Accident/ Workman's compensation patients only:

Date of the accident_____ Policy Type_____

Claim Number_____ Name of the Adjuster_____

Were you taken to the Emergency room? _____

Was there any imaging done for this accident? _____ If yes, where? _____

Have you been seen by another health care provider for this accident? If yes, who and When?

_____

_____

_____

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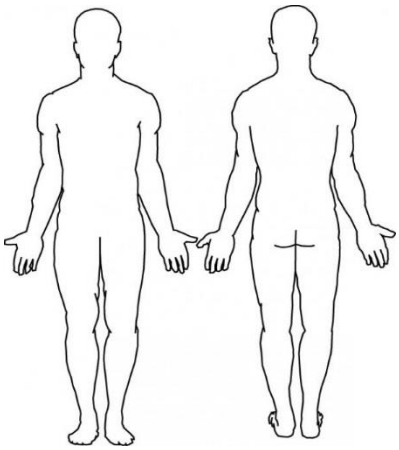
Tell us about your Condition

Mark areas of pain on the figures below



What is your primary reason for your visit?

_____

_____

When did you condition start?

_____

What type of pain are you experiencing?

_____

On a scale of 1-10, rate the severity of your pain:

(1 = feels great, 10 = debilitating)

1 2 3 4 5 6 7 8 9 10

What makes your condition worse? _____

What makes your condition better? _____

How frequent are your symptoms? Occasional / Frequent / Constant

Does your pain radiate to another part of your body? _____

If yes, Where? _____

When do your symptoms occur most frequently? _____

What time of day are your symptoms the worst? _____

Do your symptoms wake you at night? _____

Have you seen another healthcare provider for this condition? If yes, please list name, type of provider and where you were seen _____

_____

_____

_____

Is there anything else the Doctor should know about your condition?

_____

_____

_____

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Health History

Have you had chiropractic care before? _____ If yes, When_____

Family Physician_____

Current medication please list below **ALL** medications including supplements OR bring in a list of your medications

_____

_____

_____

_____

Are you allergic to anything? _____ if yes, please list_____

Previous surgeries and dates of surgery_____

Check all that apply to you:

Do you have previous **PERSONAL** history of:

- Abnormal bleeding
- Alcohol abuse
- Allergies
- Anemia
- Arthritis
- Artificial bones/joints
- Asthma
- Autoimmune disorder
- Cancer
- Chemotherapy
- Colitis
- Connective tissue disorder
- Congenital heart defect
- Depression
- Diabetes
- Dizziness
- Difficulty breathing
- Drug abuse
- Emphysema
- Epilepsy
- Fainting spells
- Fatigue
- Glaucoma
- Gout
- Headaches
- Heart problems
- Hepatitis
- High blood pressure
- HIV/AIDS
- Hospitalized for any reason
- Kidney Problems
- Liver disease/problems
- Low blood pressure
- Lupus
- Lyme's disease
- Osteoporosis
- Osteopenia
- Pacemaker
- Persistent cough
- Psychiatric problems
- Radiation treatment
- Rheumatoid arthritis
- Sciatica
- Scoliosis
- Seizures
- Shingles
- Sinus problems
- Sleep issues
- Stroke
- Suicidal tendencies
- Thyroid problems
- TMJ issues
- Tonsillitis
- Tremors/ticks
- Tuberculosis
- Ulcers

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Family Medical history:

Illness_____ Relation_____ age of onset_____

Illness_____ Relation_____ age of onset_____

Illness_____ Relation_____ age of onset_____

Illness_____ Relation_____ age of onset_____

Check all that apply to you:

- Been in a major motor vehicle accident
  Date:_____
- Had a concussion
  Date:_____
- Have been knocked unconscious
  Date:_____
- Used a walker or a cane
- Have broken any bone
  Date:_____
- Have had any impacts, falls, jolts that may have injured the spine
- Read for a prolonged amount of time
- During the day I mostly:
  - Sit
  - Stand
  - Drive
  - Desk work
  - Mechanical work
  - Heavy lifting
- Wear a foot insert, heel lift or orthotics
- Smoke/use any form of tobacco
- Spend prolonged time on the computer or phone
- Use phone/tablet while laying down
- How old is your mattress?
  _____
- What position do you sleep in?
  _____
- How many hours do you sleep a night?
  _____
- How much regular exercise do you perform?
  _____
- On a scale of 1-10, rate your healthy eating habits
  1 2 3 4 5 6 7 8 9 10
- What additional health goals do you have?
  _____
  _____
  _____

Women only: check all that apply to you:

- Using birth control
- Pregnant
  - If yes how far along?
    _____
- Nursing
- Irregular or painful periods
- Menopause
  - At what age_____