

Pank Chiropractic Intake Form

Date: _____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Cell Phone (____) _____ - _____ **Email** _____

Date of Birth ____/____/____

Sex: Male Female

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Widowed

Employment Status: Employed Unemployed FT Student PT Student Other _____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | | |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Other _____ | | | |

Allergies: (Check all that apply to you)

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: (Check all that apply to you)

- | | | | |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Chew Tobacco: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional | <input type="checkbox"/> always | <input type="checkbox"/> never |
| Other _____ | | | |

Family History: (Check all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____ | | |

Occupational Activities: (Check one that best describes your job description)

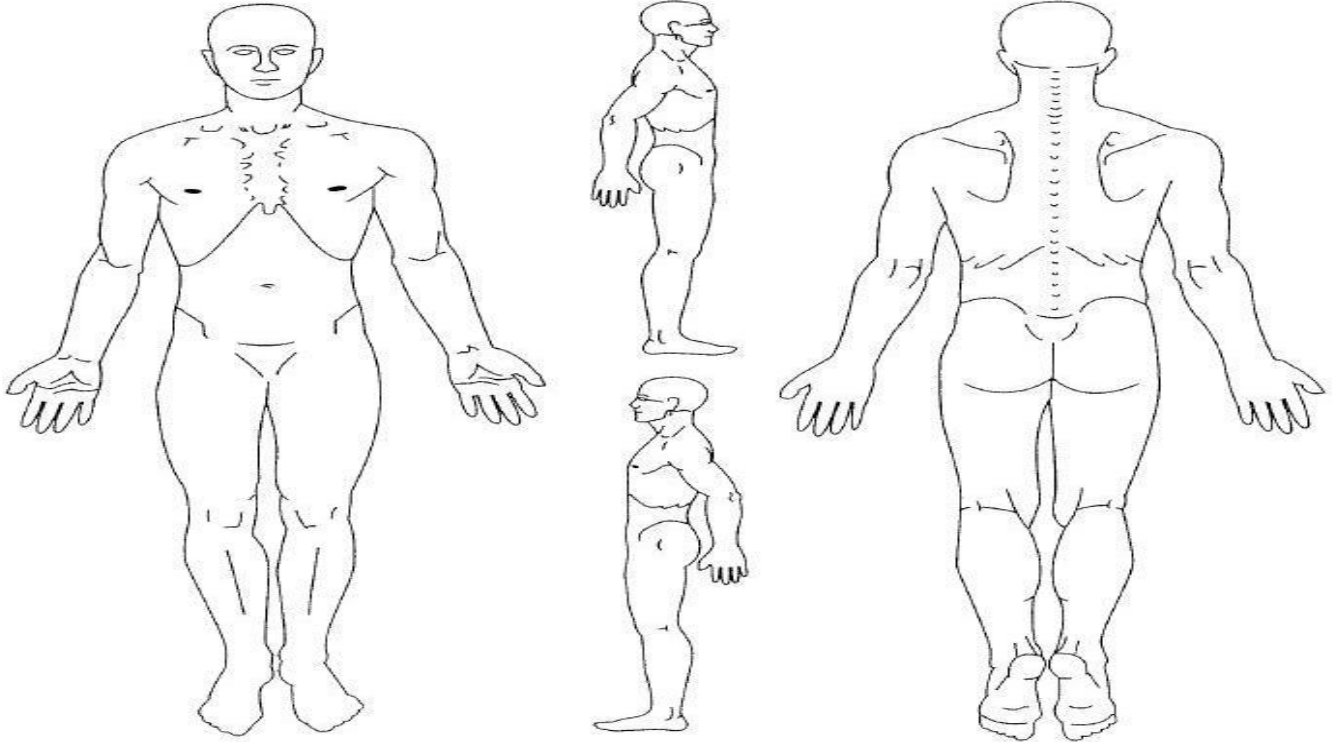
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Other _____ | | | |

Doctor's Signature _____

Are you pregnant? Yes _____ No _____ N/A _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Other _____ |

PATIENT SIGNATURE: _____ Date: _____

SIGNATURE OF PHYSICIAN: _____ Date: _____