New Patient Chiropractic Intake Form

Full Name:_____ Date of birth: _____ Age: _____ Sex: M / F
Number of children: _____ Please circle, if applicable: pregnant trying to conceive lactating

Health Goals
Please provide us with one to three of your top healthcare goals you hope to accomplish with our care team at Freedom Health Center of Minnesota.

1.
2.
3.

Commitment towards making valuable changes 1-10 (10 being most): 1 2 3 4 5 6 7 8 9 10

History of Present Illness
Describe the symptoms that bring you into the clinic:
_____
When did your symptoms described above start?
_____
How did the symptoms you described above start?
_____
Please describe where on your body the pain or other symptoms are located.
_____
How often do you experience your symptoms?
Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)
What describes the nature of your symptoms?
Sharp Dull Ache Numb Shooting Burning Tingling
How are your symptoms changing? Improving No change Worsening
During the past 4 weeks, indicate the average intensity of your symptoms - 1-10 (10 being worst): _____
In the past 4 weeks, how much of the time has your condition interfered with your normal work (including both work outside the home and housework)?
Not at all A little bit Moderately Quite a bit Extremely
During the past 4 weeks, how much of the time has your conditions interfered with your social activities?
All of the time Most of the time Some of the time A little of the time None of the time
Rate your overall health 1-10 (10 being best): _____
Which other providers have you seen for your current symptoms? _____
_____
What test have you had for your current episode of symptoms and when were they performed?
X-rays CT Scan MRI Lab Work Other None
Have you had similar symptoms in the past? Yes / No

Review of Systems

Please circle to indicate Yes (Y), No (N) or Past (P). If Yes (Y), please circle the concerns you have.

Y N P	Skin: rash, hives, eczema, psoriasis, warts, cancer, abnormal moles, itching, acne, bumps on backs of arms or other skin concerns
Y N P	Head: migraines, headaches, concussion/brain injury or other head concern
Y N P	Neuro: brain fog, dizziness, numbness, tingling, burning, tremor, cognitive decline, seizures, paralysis or other neuro concern
Y N P	Nose: nose bleeds, polyps, congestion, problems smelling or other nose concern
Y N P	Eyes: dryness, itching, vision changes, watery, pain, redness or other eye concern
Y N P	Ears: infections, ringing, hearing changes, or other ear concerns
Y N P	Mouth/throat/neck: cavities, gum disease, dentures, sores, neck stiffness, goiter, sore throat, swollen glands, difficulty swallowing
Y N P	Cardiovascular: chest pain, murmurs, palpitations, heart attack, edema, hypertension, arrhythmias, low blood pressure
Y N P	Respiratory: asthma, shortness of breath, pneumonia, wheezing, bronchitis, cough, emphysema or other respiratory concerns
Y N P	Musculoskeletal: weakness, stiffness, tension, pain, cramps or other musculoskeletal concerns
Y N P	Male: STI, discharge, pain, hernia, prostate disease, erectile dysfunction, low libido, frequent nighttime urination or other male concerns
Y N P	Urinary: incontinence, urgency, kidney stones, blood in urine, frequent infections, pain with urination or other urinary concerns
Y N P	Immune: autoimmunity, frequent infections, allergies, or other immune concerns
Y N P	Gastrointestinal: abdominal pain, nausea/vomiting, bloating, gas, belching, diarrhea, constipation, heartburn, hemorrhoids, change in appetite or other GI concerns
Y N P	Mental/emotional: depression, anxiety, eating disorder, suicidal, fear/panic, irritability, bipolar, obsessive, psych hospitalization or other mental/emotional concerns
Y N P	Female: irregular periods, abnormal pap, PMS, STI, vaginitis, discharge, odor, heavy bleeding menstrual cramping, pain with intercourse, low libido, or other female concerns To be completed by females only: 1st day of LMP: _____ Age of First Menses: _____ Age of Menopause: _____ # of pregnancies: _____ # of live births: _____ # of miscarriages/abortions: _____

Family History

Family Member	Age	Health Conditions, Reason of Death
Mother		
Father		
Maternal grandparents		
Paternal grandparents		
Siblings: ___ Number		
Children ___ Number		

Do you have any allergies? If yes please indicate what they are and the reaction you have.
_____

What medications have you taken in the past month? (Please provide name, dosage and frequency)
_____
_____

What supplements have you taken in the past month? (Please provide name, dosage and frequency)
_____
_____

Sleep: Average bed time:_____ Average wake time:_____ Sleep satisfaction 1-10 (10 being most): _____
I struggle with: falling asleep staying asleep night terrors snoring grinding teeth unrested
Energy: Rate your average energy 1-10 (10 being most): 1 2 3 4 5 6 7 8 9 10
Energy level is affected by: _____
Exercise: Activity type: _____ Other hobbies you enjoy:
Frequency of activity: _____ days/week _____
Duration of activity: _____ minutes _____
Intensity: low moderate vigorous
Water intake: _____ oz/day Water source: tap well distilled reverse osmosis filtered
Do you consume caffeine? YES / NO If yes, how much and how often? _____
Do you consume alcohol? YES / NO If yes, how much and how often? _____
Do you use tobacco? YES / NO If yes, how much and how often? _____
Do you use recreational drugs? YES / NO If yes, how much and how often? _____
Any history of substance abuse? YES / NO - If YES, please specify: _____

Current Weight:_____ Weight one year ago:_____ Ideal weight:_____ Current Height:_____

Past Medical History

Please provide any medical conditions you have been diagnosed with.

DATE	PREVIOUS DIAGNOSIS	OUTCOME/TREATMENT

Have you had any major surgeries or injuries? Please provide details of the injury/surgery and approximate dates along with other details you can recall.

DATE	SURGERY, EVENT, HOSPITALIZATION	OUTCOME