

North Brunswick Chiropractic & Acupuncture

509 Olde Waterford Way, STE 204 Leland, NC 28451

910-371-1200

Patient In-Take Forms

PATIENT INFORMATION

Name: _____ Date: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Social Security Number: ____/____/____
Occupation: _____
Employer: _____
Date of Birth: _____ Age: _____ Sex: M F
How did you hear about us? _____
Marital Status: Married Divorced Single Widowed
Spouse's Name: _____
Spouse's Occupation: _____
How many children do you have? _____
Emergency Contact: _____
Relationship: _____ Phone: _____
Primary Care Physician: _____

Computer Records

Your medical records are kept on a computer generated system that requires you to create a user name and password. Please select a username and password that is easy for you to remember.

Username: _____

Password: _____

At each visit you will check in at the front computer using the above information. Our staff can access this information if it is ever lost or forgotten.

To ensure security of your health information please select and answer **ONE** of the following security questions.

Mother's maiden name: _____

Pet's name: _____

City where you were born: _____

City where you were married: _____

Where you were on 9/11: _____

PATIENT CONDITION

Reason for Visit: _____

Describe how symptoms began: _____

Is this problem due to an auto accident or work related injury? Yes No If yes, when did it occur? _____

Date when symptoms appeared: _____ Did it begin: Gradually Suddenly Progressed over time

Is the Pain on the: Left Right Both How much of the day do you feel symptoms? 100% 75% 50% 25% 10%

Are the symptoms getting: Worse Better Staying the Same Have you had anything like this before? Yes No

What makes the symptoms worse? _____

What relieves the symptoms? _____

Describe the Pain: Burning Sharp Numb Stabbing Dull Ache
Radiating Shooting Tightness Tingling Throbbing

Does the pain radiate into your: (circle) Arms Legs Head Does not radiate

Please rate your pain on a scale of 0-10 where 0 = No Pain and 10 = Worst Pain Possible.

0 1 2 3 4 5 6 7 8 9 10

What have you already done to try and resolve this problem?

Over the counter medication Prescription medication Physical Therapy Surgery Hot/Cold
Chiropractic Massage Therapy Acupuncture Nutritional Supplements Other _____

On a scale of 1 to 10 (1 being the least, 10 being the most) how committed are you in wanting to get this problem taken care of once and for all?

1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Allergies: Animals _____ Aspirin _____ Bee Stings _____ Chocolate _____ Dairy _____ Dust _____ Eggs _____ Latex _____
 Mold _____ Penicillin _____ Pollen _____ Seasonal _____ Shellfish _____ Soap _____ Wheat _____ Other _____

Do you have any metallic implants, pacemakers, metallic sutures, etc. . ? Yes No

Are you pregnant? Yes No

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____
Accidents (auto/sport/work)	_____	_____

MEDICATIONS: Please list any medications you are taking and what they are for.

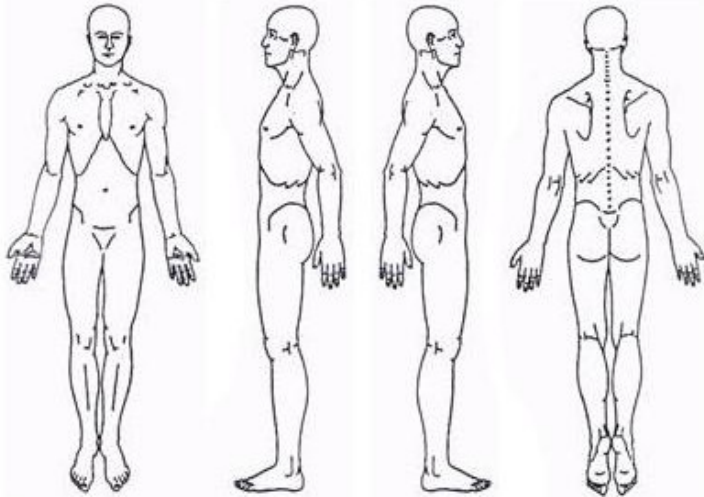
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: Please indicate family members who have/had any of the following

Arthritis: _____	Hypertension: _____
Cancer: _____	Heart Disease: _____
Diabetes: _____	Stroke: _____
Thyroid: _____	

Please check any of the symptoms you have noticed (= Previously = Now)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Low Back Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Knee Pain/Stiffness | <input type="checkbox"/> <input type="checkbox"/> Ear Problems | <input type="checkbox"/> <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> <input type="checkbox"/> Mid Back Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Nose/Sinus Problems | <input type="checkbox"/> <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> <input type="checkbox"/> Upper Back Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> <input type="checkbox"/> Throat Problems | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Neck Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Pain Restricts Daily Activity | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> Excessive Sweating |
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> H or L Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> <input type="checkbox"/> Frequent Cold/Flus |
| <input type="checkbox"/> <input type="checkbox"/> Migraine | <input type="checkbox"/> <input type="checkbox"/> Tiredness / Fatigue | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> <input type="checkbox"/> Radiating Pain down Arms | <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Female/Menstrual Problems |
| <input type="checkbox"/> <input type="checkbox"/> Numbness/Tingling in Arms | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> <input type="checkbox"/> Inability to Control Bladder |
| <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> <input type="checkbox"/> Impotence |
| <input type="checkbox"/> <input type="checkbox"/> Shoulder Pain/Stiffness | <input type="checkbox"/> <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> <input type="checkbox"/> Intestine Problems | <input type="checkbox"/> <input type="checkbox"/> Pain w/ Coughing or Sneezing |
| <input type="checkbox"/> <input type="checkbox"/> Elbow Pain/Stiffness | <input type="checkbox"/> <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> <input type="checkbox"/> Colorectal Problems | <input type="checkbox"/> <input type="checkbox"/> Pain at stools |
| <input type="checkbox"/> <input type="checkbox"/> Wrist/Hand Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Problems | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Hip Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Memory Loss | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> Unable to Work |
| <input type="checkbox"/> <input type="checkbox"/> Radiating Pain down Legs | <input type="checkbox"/> <input type="checkbox"/> Vision/Eye Problems | <input type="checkbox"/> <input type="checkbox"/> Diabetes / Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Inadequate Water Intake |
| | | | <input type="checkbox"/> <input type="checkbox"/> Other _____ |



Please mark off the areas of your complaint(s) on the diagram. Use the following symbols of the pain diagram to accurately describe your condition.

PPP	Pain
NNN	Numbness
TTT	Tingling
BBB	Burning
CCC	Cramping

Patient Signature _____

Date _____

SOCIAL HISTORY & LIFESTYLE

It is important that we understand your general lifestyle as it often has a significant impact on your overall health. Please check mark the box which **most closely** describes your general lifestyle for each question.

1. Smoking: (For cigars, pipes, or chewing tobacco estimate the amount of tobacco used per day.)

I do not smoke. I smoke 1/4 pack or less per day. I smoke 1/2 pack per day. I smoke 3/4 pack per day. I smoke 1 pack per day.

2. Alcohol: On average how many alcoholic drinks do you consume per week?
(one drink = 12 oz. of beer, 4 oz. of wine, 1 wine cooler, 1 cocktail, or 1 shot of hard liquor)

None 1 drink/week 2-7 drinks/week 8-14 drinks/weeks 15-21 drinks/week +22 drinks/week

3. Caffeine: On average how many caffeinated drinks do you consume per day? (soda, coffee, tea)

None 1 drink/day 2 drinks/day 3 drinks/day 4 drinks/day 5+ drinks/day

4. Exercise: For this questions, exercise means at least 30 minutes of activity.

I exercise 3-5 Days/week I exercise 2 Days/week I exercise 1 Days/week I exercise 1 Days/month I am not exercising

5. Diet: Fruits and Vegetables are abbreviated as F&V.

I eat 3 or more servings of F&V per day I eat 2 servings of F&V per day I eat 1 serving of F&V per day I eat 1-4 servings of F&V per week I eat NO servings of F&V per week

6. Sleep: How many hours of undisturbed sleep to you get each night?

Less than 6 hours 6 hours 7 hours 8 hours More than 8 hours

7. Stress: Rate the level of stress in your life on a daily basis 0 = NO STRESS and 10 = HIGH STRESS.

0 1 2 3 4 5 6 7 8 9 10

8. Health: How would you rate your overall health.

Excellent Very Good Good Fair Poor

Patient Signature _____

Date _____