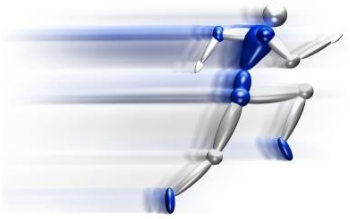


North Brunswick Chiropractic & Acupuncture

509 Olde Waterford Way, STE 201 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. For your protection, please select a username and password that is easy for you to remember.

Username: _____
Password: _____

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
Please select symptom intensity: Minimum Mild Moderate Severe Unbearable
What have you tried that makes the symptoms better? Please indicate:
Medication Physical Therapy Surgery Heat Cold
Chiropractic Massage Therapy Acupuncture Nutritional Supplements Other _____

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

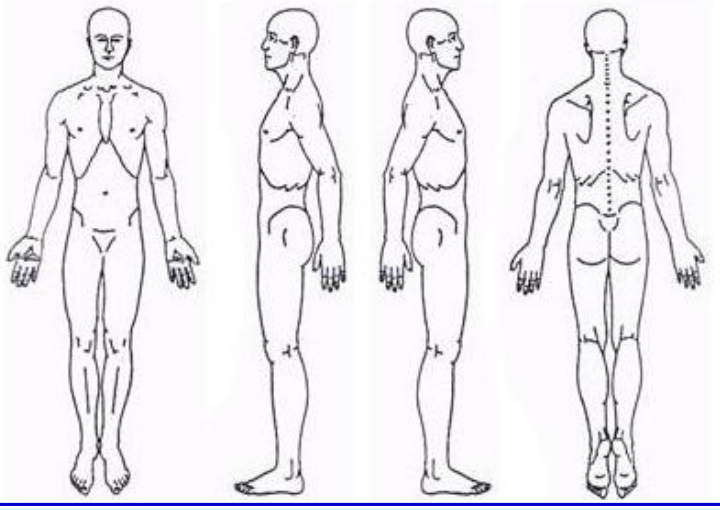
Arthritis:_____ Hypertension:_____
Cancer: _____ Heart Disease:_____
Diabetes: _____ Stroke: _____
Thyroid: _____

Please select your past medical history:

- ☐ Ankle Pain
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Hand Pain
- ☐ Hepatitis
- ☐ Jaw Pain
- ☐ Leg Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Parkinson's Disease
- ☐ Shoulder Pain
- ☐ Sprain/Strain
- ☐ Tumors
- ☐ Arm Pain
- ☐ Back Pain
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Eye/Vision Problems
- ☐ Foot Pain
- ☐ Headaches/Migraines
- ☐ High Blood Pressure
- ☐ Joint Stiffness
- ☐ Low Back Pain
- ☐ Minor Heart Problems
- ☐ Neurological Disorder
- ☐ Polio
- ☐ Significant Weight Change
- ☐ Stroke/Heart Attack
- ☐ Ulcers
- ☐ Arthritis
- ☐ Broken Bones
- ☐ Depression/Anxiety
- ☐ Elbow Pain
- ☐ Fainting
- ☐ Genetic Spinal Disorder
- ☐ Hearing Problems
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Menstrual Problems
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Prostate Problems
- ☐ Spinal Cord Injury
- ☐ Stomach Problems
- ☐ Wrist Pain

Any Significant Problems with:

- ☐ Eyes
- ☐ Ears/Nose/Throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Skin/Breast
- ☐ Psychiatric
- ☐ Endocrine
- ☐ Blood/Lymph
- ☐ Immune
- ☐ 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

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 _____