River City Chiropractic New Patient Intake

Today's Date: _____ **Who Referred You**?_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

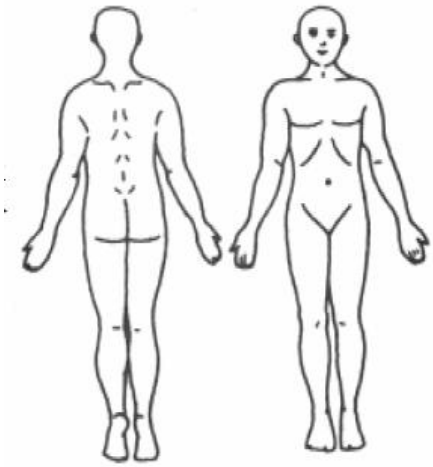
E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Occupation: _____ Employer Name/Company:_____Work Phone:_____

Marital Status: ❑ Single ❑ Married Emergency Contact:_____ Phone:_____

Do you have Insurance: ❑ Yes ❑ No Do you have kids under 18? ❑ Yes ❑ No If Yes, How Many? _____
Preferred Contact Method: ❑ Call ❑ Text ❑ Email

Is Your Condition(s) Related To An Accident? ❑ Yes ❑ No. If Yes, Work ❑ *or Auto* ❑



Please identify the condition(s) that brought you to this office:
Primary: _____
Second: _____
Third: _____

On a scale of **1** to **10** with **10** being the **worst pain** and zero being no pain,
rate your above complaints **at their absolute WORST** by ***circling the number***:

Primary or chief complaint is : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 –10

PLEASE MARK the areas on the Diagram to the right with the following **letters**
to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull
A = Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Please mark P – PAST, C – Current, N – NEVER to all the following symptoms, even if they seem minimal or not related to your current problem.

___ Headaches / Migraines	___ Neck Pain / Stiff	___ Gastrointestinal	___ Heart / Vascular
___ Numbness / Tingling	___ Upper Back Pain / Stiff	___ Lower Back Pain / Stiff	___ Lung / Breathing
___ Dizziness / Balance	___ Mid Back Pain / Stiff	___ Sinus / Allergies	___ Seizures

List any other conditions or health problems being treated for: _____

List any past surgeries or major injuries: _____

Please CHECK all symptoms or diseases that apply to your **family's history**.

☐ Headaches/Migraines	☐ Neck Pain/Stiff	☐ High Blood Pressure	☐ Diabetes
☐ Numbness/Tingling	☐ Upper Back Pain/Stiff	☐ Lower Back Pain/Stiff	☐ Irritable/Depression
☐ Dizziness/Balance	☐ Middle Back/Stiff	☐ Heart Disease	☐ Cancer

Please CIRCLE YES or **NO** to all that apply to your current/past **social history**

Smoking: **YES/NO** Alcohol: **YES/NO** (# drinks per week: _____) Exercise: **YES/NO** (# days per week: _____)

Please list any medications/ drugs/ supplements you are currently taking: _____

_____

Patient Signature or Legal Guardian: _____Date:_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date

Doctor Signature:_____Date:_____