Peck Chiropractic New Patient Intake Form

Full Name (Legal Name) ______________________________ DOB ______/_____/______Gender: M / F

Address:______________________________City______________State_____Zip__________

Cell Phone: ____________________ Home Phone: ________________ Work Phone: _______________

Preferred Number: Cell Home Work

Marital Status: S M W D Spouses Name:_____________________________

Referred By: ______________________________________

INSURANCE INFORMATION: (check) _____Cash _______Group Health ______ Covered CA ______Medicare

Insurance Co.______________________ Insured's Name___________________________

Claims mailing address:______________________________City:____________Sate_____Zip________

ID#_________________________ Group#___________________ SSN________________

SYMPTOMS

What is your major complaint?____

Other complaints?____

When did the problem start:____

Have you had this condition in the past? Yes No

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other:__________________

OTHER DOCTORS/TREATMENT FOR THIS CONDITION (circle): MD DC DO DDS Physical Therapist

Doctors Name:____

Did the treatment help? Yes No

OTHER

List any surgical operations you have had:____

____

Are you taking any medication? Yes No List:_____________________________________

____

Any non prescription drugs or vitamns?____

(continued)

IMPORTANT: Please check (X) all present symptoms.

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers

MID-BACK:
- ☐ Mid-back pain
- ☐ Location ____________
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat ____________
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroiliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when ____________
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R - L)
- ☐ Pain in hip joint (R - L)
- ☐ Pain down leg (R - L)
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R - L)
- ☐ Pins & needles in legs (R - L)
- ☐ Numbness of leg (R - L)
- ☐ Numbness of feet (R - L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R - L)
- ☐ Swollen feet (R - L)

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep ______
- ☐ Loss of sleep ______ hrs /night
- ☐ Loss of weight ______ lbs
- ☐ Gain weight ______ lbs
- ☐ Coffee ______ cups/day
- ☐ Tea ______ cups/day
- ☐ Cigarettes ______ pack/day
- ☐ Other ____________
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

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I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment no matter insurance status

Patient Signature:______________________________ Date: