RENO CHIROPRACTIC CLINIC, P.A.

1610 E Lincoln St Wichita, KS 67211
316-524-5700
CHIROPRACTIC INTAKE FORM

PATIENT INFORMATION DATE_____

Name _____ Social Security _____ - ____ - _____ Age _____ DOB _____

Address _____ City _____ St _____ Zip Code _____-_____

Phone (_____) _____-_____ Reminders for Appointments? ◯Yes ◯No Marital:◯M ◯S ◯W ◯D Sex: ◯M ◯F

Your Employer _____ Referred by _____

Name of Significant Other/Parent _____ Employer _____

Emergency Contact _____ Phone _____

Is this condition due to injury or sickness arising out of employment? _____
Is this condition due to injury or sickness arising from an Auto Accident? _____
Is this condition due to injury or sickness arising from another accident? _____

Dates symptoms appeared or accident happened _____ If other, please describe?_____

Review Of Systems

Do you have, or have had, any of the following? Please mark all that apply to you.

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯Yes ◯No If yes _____

Your Primary Care Physician (PCP) _____

Major surgeries or Operations? _____

What medications or drugs are you taking?_____

HEALTH INSURANCE: YES ◯ NO ◯ Health Insurance Carrier _____

Insured's Name: _____ Insured's DOB: _____

Insured's Empl: _____ Insured's SSN:_____

I authorize direct payment of medical benefits to Reno Chiropractic Clinic, P.A. and release of medical information necessary to process my insurance claims.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

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PATIENT HISTORY FORM

We must assess your condition to understand how your reason for seeking care affects your ability to manage everyday activities.

Patient Reason for Seeking Care ☐ *Neck* ☐ *Back* ☐ *Low Back* ☐ *Other:*_____

- On a scale of 0-10, with 10 being the worst, choose the number that best describes the intensity of symptoms on average:
  ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10
- When you are awake, what percentage of the time do you experience your symptoms at the above intensity:
  ◯10 ◯20 ◯30 ◯40 ◯50 ◯60 ◯70 ◯80 ◯90 ◯100
- When did the symptoms begin? _____ How? _____ ◯Gradually or ◯Suddenly?
- What makes the symptoms worse? (Mark all that apply):
  ☐Bending Forward ☐Bending Backward ☐Tilting to left ☐Tilting to right ☐Turning to left ☐Turning to right
  ☐Twisting left ☐Twisting right ☐Sitting ☐Standing ☐Sitting to Standing ☐Lifting ☐Driving ☐Walking
  ☐Running ☐Nothing ☐Any Movement ☐Other (please describe): _____
- What makes the symptoms better? (Mark all that apply):
  ☐Rest ☐Ice ☐Heat ☐Stretching ☐Exercise ☐Massage ☐Pain Medication ☐Muscle Relaxers ☐Nothing
  ☐Other (please describe): _____
- Describe the quality of the symptoms (Mark all that apply):
  ☐Sharp ☐Dull ☐Achy ☐Burning ☐Throbbing ☐Piercing ☐Stabbing ☐Deep ☐Nagging ☐Shooting Stinging
  ☐Other (please describe): _____
- Do the symptoms radiate to another part of your body (circle one): ◯YES ◯NO If yes, where? _____
- What time of day are your symptoms worse? (Mark all that apply)
  ☐Morning ☐Afternoon ☐Evening ☐Night ☐Unaffected by time of day

Functional Rating

Please choose the number which most closely describes your condition right now

1. Pain Intensity

☐0	☐1	☐2	☐3	☐4
None	Mild	Moderate	Severe	Worst

2. Sleeping

☐0	☐1	☐2	☐3	☐4
Perfect	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

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

☐0	☐1	☐2	☐3	☐4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Needs to go slowly	Moderate Pain; Needs some assistance	Severe Pain; Needs 100% Assistance

4. Travel (driving, etc.)

☐0	☐1	☐2	☐3	☐4
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

☐0	☐1	☐2	☐3	☐4
Can do usual work plus extra	Can do usual work but no extra	Can do 50% of work	Can do 25% of work	Cannot work

6. Recreation

☐0	☐1	☐2	☐3	☐4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any

7. Frequency of Pain throughout the Day

☐0	☐1	☐2	☐3	☐4
0%	25%	50%	75%	100%

8. Lifting

☐0	☐1	☐2	☐3	☐4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

☐0	☐1	☐2	☐3	☐4
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

☐0	☐1	☐2	☐3	☐4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain after any standing

Patient or Guardian Signature _____ **Date** _____

Print Name _____