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 (_____) _____-_____ Phone Provider for Text Reminders _____ (Verizon, AT&T, Sprint, etc.) 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 _____

09/2019

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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 _____

- On a scale of 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:

  1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  10 20 30 40 50 60 70 80 90 100 (Circle one)

- When did the symptom begin? _____ How? _____ Gradually or Suddenly?
- What makes the symptom 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 symptom better? (Mark all that apply):

  ☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Pain Medication ☐ Muscle Relaxers ☐ Nothing
  ☐ Other (please describe): _____

- Describe the quality of the symptom (Mark all that apply):

  ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Piercing ☐ Stabbing ☐ Deep ☐ Nagging ☐ Shooting Stinging
  ☐ Other (please describe): _____

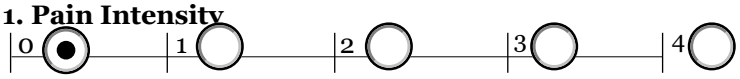
- Does the symptom radiate to another part of your body (circle one): YES NO Where? _____
- Is the symptom worse at certain times of the day or night? (Mark one)

  ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

Functional Rating

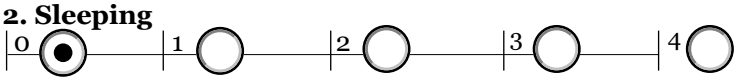
Please choose the number which most closely describes your condition right now.

1. Pain Intensity



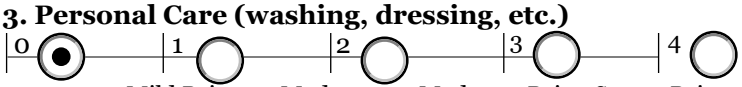
None Mild Moderate Severe Worst

2. Sleeping



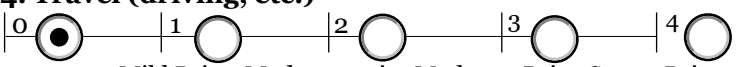
Perfect Mildly Disturbed Moderately Disturbed Greatly Disturbed Totally Disturbed

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



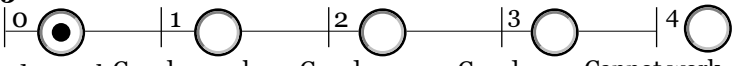
No Pain; No Restrictions | Mild Pain; No Restrictions | Moderate Pain; Needs to go slowly | Moderate Pain; Needs some Assistance | Severe Pain; Needs 100% Assistance

4. Travel (driving, etc.)



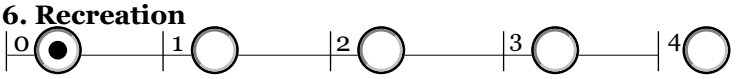
No Pain on long trips | Mild Pain on long trips | Moderate pain on long trips | Moderate Pain on short trips | Severe Pain on short trips

5. Work



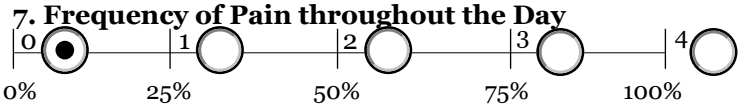
Can do usual work plus extra | Can do usual work but no extra | Can do 50% of work | Can do 25% of work | Cannot work

6. Recreation



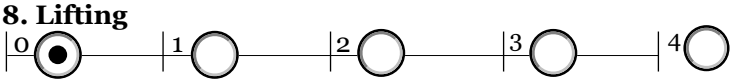
Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any

7. Frequency of Pain throughout the Day



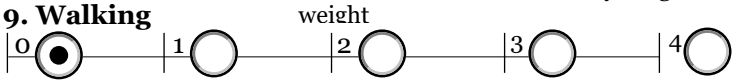
0% 25% 50% 75% 100%

8. Lifting



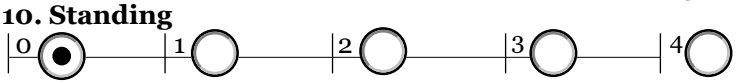
No Pain with heavy weight | Increased Pain with heavy weight | Increased Pain with moderate weight | Increased Pain with light weight | Increased Pain with any weight

9. Walking



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 ½ hour | Increased pain after any standing

Patient or Guardian Signature _____ **Date** _____

Print Name _____

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