FEDDES CHIROPRACTIC

Advanced Chiropractic & Acupuncture

New Patient Intake Form

Dr. Tara Mckinney Dr. Joshua Feddes

Personal Information

Name: _____ Address: _____

City: _____ State: _____ Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M or F

Cell #: _____ E-Mail Address: _____

Employer: _____ Type of Work: _____

Business Phone: _____ Social Security #: _____

Name of Spouse: _____ Spouses Employer: _____

Referred to this office by: _____ Name and Ages of Children: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who is Responsible for your Bill: □ Auto Insurance □ Medicare □ Workers Comp □ Spouse

Personal Health Insurance(Name): _____ Health Card # _____

Insured Person's Name: _____ Date of Birth: _____

Current Health Condition

Unwanted Health Condition: _____

Other Doctors Seen for this Condition: ☐ Yes ☐ No Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? ☐ Y ☐ N

Is condition: □ Job related □ Auto Accident □Home Injury □ Injury □ Other: _____

Date of Accident: _____ Time of Accident: _____

Do you suffer from any condition other than that which you are now consulting us? _____

Do you suffer from any blood clotting disorders? ☐ Y ☐ N _____

Are you currently on Hormone Replacement Therapy? ☐ Y ☐ N _____

Past Health History

Majory Surgeries/Operations: _____

Major Accidents or Falls: _____

Hospitalizations (other than above): _____

Previous Acupuncture Care: ☐ Y ☐ N Dr's Name and Approx. Date of last Visit: _____

Demographics Data (Necessary for Electronic Health Records)

Language: _____ Smoking status: ☐ Never □ Everyday □ Ex-smoker (Start date: _____)

Race: _____ Ethnicity: □ Hispanic □ Not Hispanic □ Decline to Answer

Rx Allergies: _____ Reaction: _____

Current Medications: _____

Vitals (Office use only)

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems affect your overall care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rhematic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Exzema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes/tobacco
- ☐ White sugar
- ☐ Vegetarian

Have you been tested HIV positive? ☐ YES ☐ NO

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculo-skeletal Code

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Jaw pain
- ☐ General Stiffnes

Gastro-intestional Code

- ☐ Gas bloating after meals
- ☐ Heartburn
- ☐ black/bloody stools
- ☐ Colitis
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Weight Trouble
- ☐ Diarhea
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Flatulence
- ☐ Vomitting
- ☐ Abdominal Cramps
- ☐ Loose stools
- ☐ Gall Bladder Problems

Females Only

When was your last Period?

_____

Are You Pregnant?

☐ YES ☐ NO ☐ Not Sure

Nervous System Code

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfullness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling
- ☐ Stress
- ☐ Excessive Perspiration
- ☐ Tremors

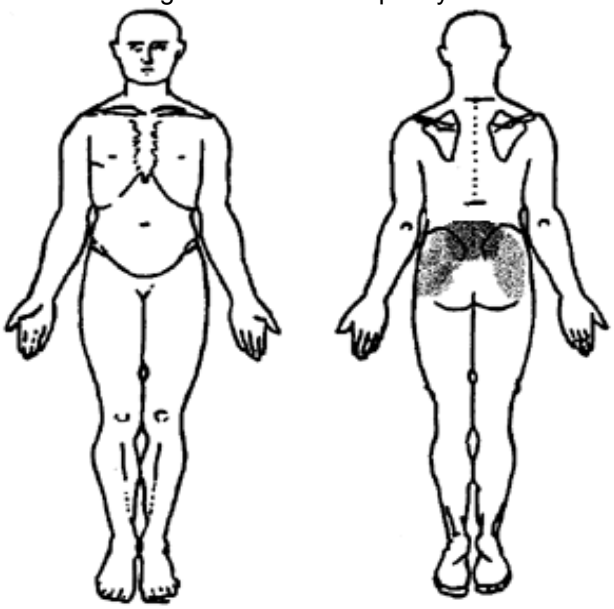
Genirto-Urinary Code

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R Code

- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Stroke
- ☐ Lung Problems/Congestion
- ☐ Ankle Swelling

Please Indicate your area(s) of Discomfort on Diagram with a number from 1 through 10.With 1 being very little pain and 10 being the most severe pain you have ever had.



General Code

- ☐ Fatigue
- ☐ Allergies
- ☐ Poor Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Skin Condition
- ☐ Low Immunity

EENT Code

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ White tongue

Male/Female Code

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain; Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

Family History

The following members have a same or similar problems as I.

- ☐ Mother ☐ Child
- ☐ Father ☐ Spouse
- ☐ Brother
- ☐ Sister

Office Use Only

Symptom	Sev.	Quality	Radiation	Timing	Palliative	Provoked	Mechanism	Intervent
Neck pain		numb/ting	L/R Shoulder(s)	Occasinal	Nothing	Nothing	MVA	Ice
Mid back pain	MILD	Achey	L/R Arm(s)	Intermittent	exercise	exercise	Work Injury	Medical
Low back pain		Sharp	L/R Finger(s)	Frequent	lying down	lying down	Fall	P.T
Arm pain		Stabbing	L/R buttock(s)	Constant	standing	standing	Lifting	Drugs
Headache	MOD	Throbbing	L/R Hip(s)	Onset	sitting	sitting	Don't know	Chiro
Hip pain		Burning	L/R Knee(s)	123456 Days	movement	movement	Gradual onset	Surg.
Leg pain		Dull	L/R foot(feet)	123 Weeks	rest	rest	Repeat Use	Heat
Other	SEV.	Itchy	L/R toe(s).				Sports injury	Nothing