RETURN SPINAL REHAB
MOBILE CHIROPRACTIC THAT COMES TO YOU

NEW PATIENT INTAKE FORM

Patient Data

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Sex: Male Female

Social Security Number: _____-_____-_____ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Spouse Data

First Name _____ Middle Initial _____ Last Name _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Employer Data

Name _____

Your Occupation _____Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

How did you hear about Return Spinal Rehab? _____

Primary Complaint_____

Due to an Injury?_____

Onset-When and How did your primary complaint begin? _____
_____

Pain Symptoms: (in order of severity)	1. _____	Began-(Mo/Yr):	Previous Episodes:
	2. _____	Began-(Mo/Yr):	Previous Episodes:
	3. _____	Began-(Mo/Yr):	Previous Episodes:

Please mark the intensity of your pain today.

0 - NO PAIN
10 - INTENSE PAIN

Example Neck

	0	1	2	3	④	5	6	7	8	9	10
1											
2.	0		2	3	4	5	6		8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6		8	9	10

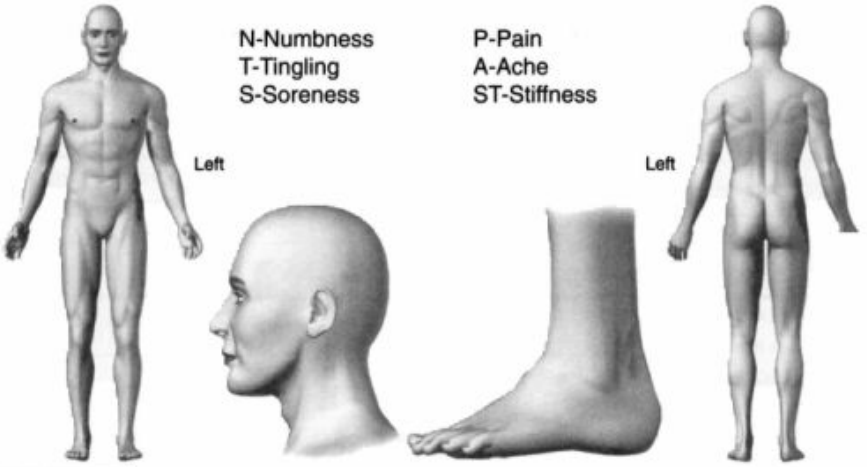
DOCTORS USE ONLY

_____
_____
_____
_____

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



HABITS

- ❑ Smoking Packs/Day:
- ❑ Drinking Alcohol:
- ❑ Caffeine Cups/Day:

EXERCISE

- ❑ None
- ❑ Light Activity
- ❑ Moderate Activity
- ❑ Active
- ❑ Very Active
- ❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother,# of: ____	❑	❑	❑	❑	❑
Sister.# of:	❑	❑	❑	❑	❑

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Muscular Disorder	Migraine Headaches	Chicken Pox	Bone Density Issue

Other _____

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular	Cervical spine	Hysterectomy
Cranial/Brain	Shoulder	Thoracic spine	Urogenital
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Carpal Tunnel	Gastrointestinal	Knee	Hernia

Other _____

Occupational Activities: (Circle which best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy/Light Manual Labor	Executive/Legal	Housekeeper	Other _____

Please list all current medications being taken

_____

_____

_____

Females-Are you pregnant? Yes_____ No _____ N/A_____

HIPAA Privacy Practices
I acknowledge that I have received and /or have been given the opportunity to review the Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

SIGNATURE OF PHYSICIAN: _____ Date _____

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