HEALING TOUCH CHIROPRACTIC
Petros, Cherra & Pirnia Corporation

Patient Intake Form

Patient Information

Name____________________ **Social Security #** ________________ **Date** __________

Date of Birth __________ **Age**: ____ **Gender**: □Male □Female **Height**: ______ **Weight**: ____ lbs.

Status: □Minor □Single □Married □Widowed □Separated □Divorced □Domestic Partner **Spouse**: ________________

Address:____________________ **Apt/Suit**: _____ **City**: __________ **State**: ____ **Zip**: _____

Home #: ____________ **Mobile #**: ____________ **Work #** ____________ **ext**: ____

Email: ____________________ **Occupation**: ____________________ **for** ____ **yrs**

Emergency Contact Name: ____________________ **Emergency Contact #** ____________

Primary Care MD: ____________________ **City**: __________ **Phone**: ____________

Health Insurance	**Auto Insurance**	**Third Party Insurance**
Insurance Name: __________	**Date of Accident**: __________	**Date of Accident**: __________
Subscriber ID: __________	**Claim #** __________	**Claim #** __________
Group/Plan # __________	**Insurance Name**: __________	**Insurance Name**: __________
Subscriber: __________	**Adjustor**: __________	**Adjustor**: __________
Relationship to Subscriber:_____	**Adjustor Ph. #** __________	**Adjustor Ph. #** __________

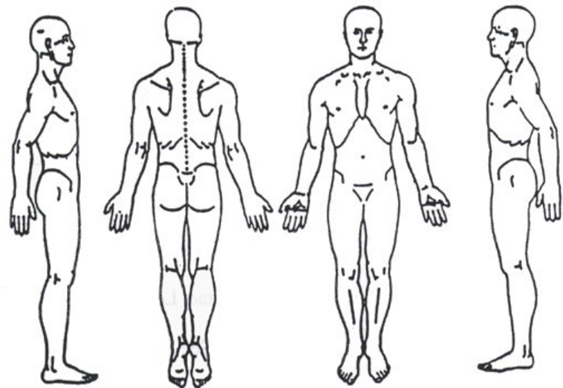
Reason for Visit: □ Emergency □Auto Injury □Sports Injury □Other Injury □ Chronic □Workers Comp □ Other ______
Date of Injury: ________ **When did symptoms begin?**________________ **Is it getting worse**? □ Yes □ No
Please describe your injury/illness: ____

____

Are you in pain?

1. Body Part: ________________ Pain:___/10
2. Body Part: ________________ Pain:___/10
3. Body Part: ________________ Pain:___/10
4. Body Part: ________________ Pain:___/10

Please mark an 'X' where you have pain:



Type of Pain: ☐ Sharp ☐Dull ☐Throbbing ☐Aching ☐ Shooting ☐Burning ☐ Tingling ☐ Shooting ☐Burning ☐ Tingling

☐Stiffness ☐Swelling ☐Numbness **Is there weakness?** ☐ Yes ☐ No **How Often**: ☐Daily ☐Intermittent ☐Constant

Activities of Daily Living Affected: ☐ Sitting ☐Standing ☐Walking ☐Running ☐ Sleeping ☐Laying ☐ Lifting ☐ Driving

☐House Chores ☐ Yard work ☐Work/School Activities ☐Other: ________________________

Do you have any emotional change due to injury?: ☐ Yes ☐ No **Explain**: ____________________

What treatment have you already received for your condition? ☐ Medication ☐Physical Therapy ☐Surgery ☐Chiropractic

☐ None ☐Other________________ **X-Ray/MRI taken?** ☐ Yes ☐ No **Findings**:________________

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Auto Injury Information

Date of Accident ____/____/______ **Approx. Time**: ________ **You Were**: □ Driver □Front Passenger □Rear Passenger
Wearing a Seatbelt? □ Yes □ No **Airbags Deploy**: □ Yes □ No **Road conditions**: □ Dry □Damp □Wet □Raining
Lighting conditions: □ Full Daylight □Dawn □Dusk □Night **Please describe how the accident occurred**:_______________
____
____

Your Vehicle? ____________________ **Speed**? ______ MPH **Other Vehicle?** ________________ **Speed**? ______ MPH

What Were Your Feelings After Accident? □ Angry □Disoriented □Dizzy □Nauseous □ Scared □Upset □Dizzy □Weak

Were you transported to Hospital via Ambulance? □ Yes □ No Which Hospital?_________________________________

Were X-Ray/MRI taken? □ Yes □ No **Findings**: ____ □ Unknown

How were your transported after the accident? □ Self □Family/Friend □Tow Truck

Did you lose consciousness? □ Yes □ No **Were You Dizzy**: □ Yes □ No **Did you hit your head?** □ Yes □ No

Where did you hit your head? □ N/A ________________________________ **Did you have any cuts or bruises?** □ Yes □ No

Where do you have cuts/bruises? ____ **Did They Require Stitches?** □ Yes □ No

Miss any days from work or school? □ Yes □No **If Yes, How Many Days?** _________ **Property Damage $**_________

Health History

Do you have any of these conditions? ☐ None ☐Diabetes ☐ Arthritis **Type**___________________ ☐ High Blood Pressure

☐ heart disease ☐ Cancer **Type**_________________ ☐ Other: ____

Any prior Surgeries? ☐ Yes ☐ No **Explain:** ____
List any past serious accidents with dates: ____

Are you taking any Medications? ☐ Yes ☐ No **List:** ____

Any Allergies: ☐ Yes ☐ No **List:** _________________________________ **Exercise:** ☐ None ☐Daily ☐Moderate ☐Heavy

Have you ever seen a Chiropractor? ☐ Yes ☐ No **Reason for Chiropractic therapy**:_____________________________

Habits: ☐ Smoking ____ Cigarettes/day ☐Drink Alcohol ______ Drinks/week ☐Coffee/Caffeine _____ drinks/day

Review of Systems

Constitutional:	□ Fever □ Chills □ Fatigue □ Poor Sleep □ Weight Loss □ Night Sweats □ Appetite Loss
ENT:	□ Vision Problems □ Altered Hearing □ Runny Nose □ Sinus Problems □ Ringing of Ears □ Ear Pain □ Nasal Congestion □ Sore Throat □ Allergies
Cardiovascular	□ Chest Pain □ Palpitations □ Leg Swelling □ Pacemaker
Respiratory	□ Pneumonia □ Wheezing □ Bronchitis □ COPD □ Shortness of Breath □ Cough □ Asthma
Gastrointestinal:	□ Nausea □ Vomiting □ Abdominal Pain □ Bowel Incontinence □ Heartburn □ Constipation/diarrhea
Genitourinary:	□ Increased Urinary Urgency □ Increased Urinary Frequency □ Painful Urination □ Blood in urine
Dermatological:	□ Rash □ Nail Problems □ Abnormal Hair Loss
Musculoskeletal:	□ Neck Pain □ Back Pain □ Joint Pain □ Muscle Pain
Hematologic:	□ Anemia □ Easy Bruising □ Abnormal bleeding □ Taking Blood Thinner □ Black/Tarry Stool
Neurologic:	□ Dizziness □ Fainting □ Hallucinations □ Sudden Headache □Seizures □ Paralysis □ **Loss of Bowel/Bladder Function** □ Loss of Balance □ Loss in Sensation □ Sudden Numbness
Psychiatric:	□ Depression □ Anxiety □ Anger Issues

For Women: **Are you Pregnant?** ☐ Yes ☐ No **How many weeks?** _____ **Are you taking Birth Control?** ☐ Yes ☐ No

Patient or Guardian Signature **X**____ **Date** _____/______/_______