NEW PATIENT INTAKE FORM

Patient Information

Name:

Birthday: Sex: ☐ M ☐ F

Address:

City: State: Zip:

E-mail Address:

Primary Phone: Phone Type: ☐ Home ☐ Mobile ☐ Work

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Do you have Health Insurance? *If **"YES"** present insurance card to front desk…* ☐ YES ☐ NO

Are your symptoms the result of an accident? *If **"YES"** please see front desk...* ☐ YES ☐ NO

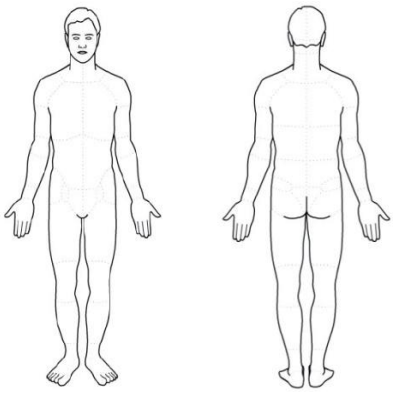
Have you ever received chiropractic care? ☐ YES ☐ NO

Have you ever received massage therapy? ☐ YES ☐ NO

Whom may we thank for referring you to our office?

Areas of Complaint

PLEASE DRAW ON THE DIAGRAM *to indicate any area(s) where you are currently experiencing pain or tension…*



PLEASE LIST AREAS OF COMPLAINT & CIRCLE "R" = *right-sided*, "L = *left-sided*

○ R ○ L

○ R ○ L

◉ R ○ L

○ R ○ L

SYMPTOM FREQUENCY

☐ Constant	75-100% of awake time
☐ Frequent	51-75% of awake time
☐ Intermittent	26-50% of awake time
☐ Occasional	0-25% of awake time

SYMPTOM CHANGES

- ☐ It is worse in the morning
- ☐ It is worse in the afternoon
- ☐ It is worse in the evening
- ☐ It changes with the weather
- ☐ It does not change

SYMPTOM RELIEF

- ☐ Ice
- ☐ Heat
- ☐ Medication
- ☐ Nothing Helps
- ☐ Other

818 NW Marshall St · Portland OR 97209 · phone (503) 719.5335 · fax (503) 719.5334 · www.asula.com
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Health Information

Please ☑ If you have, or have had, any of the following symptoms to a significant degree.

- ☐ Exhaustion
- ☐ Vague Feeling of Discomfort
- ☐ Unexplained Weight Loss/Gain
- ☐ Fever
- ☐ Insomnia
- ☐ Nervousness
- ☐ Depression
- ☐ Anxiety
- ☐ Headaches/Migraines
- ☐ Allergies
- ☐ Sinus Trouble
- ☐ Weight Trouble
- ☐ Loss of Appetite
- ☐ Irritability
- ☐ Menstrual Problems

Pain or Tension?

- ☐ Neck
- ☐ Shoulders
- ☐ Low Back
- ☐ Legs
- ☐ Arms
- ☐ Hands

Digestive Trouble?

- ☐ Irritable Bowel
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Gas

Do you have any of the following today?

- ☐ Skin Rash
- ☐ Cold/Flu
- ☐ Open Cuts
- ☐ Severe Pain
- ☐ Injuries/Bruises
- ☐ Anything Contagious

Pre-Existing Conditions

Please ☑ if you have, or have had any of the conditions listed below.

- ☐ Arthritis
- ☐ Diabetes
- ☐ Blood clots
- ☐ Broken/dislocated bones
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chronic pain
- ☐ Seizures
- ☐ Stroke
- ☐ Surgery
- ☐ TMJ disorder
- ☐ Nerve pain or loss of sensation
- ☐ Varicose veins
- ☐ Disc problems or Spinal injuries
- ☐ Pregnancy
- ☐ Scoliosis
- ☐ Whiplash
- ☐ Heart condition or vascular problems
- ☐ Tendonitis / Bursitis / Muscle strain / Sprain
- ☐ Skin Condition *ie. rashes, athletes foot etc.*
- ☐ Auto-immune Condition *ie. AIDS ,fibromyalgia, chronic fatigue, lupus etc.*

☐ Allergies? *Please list:*

Comments/Other:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

What are your goals/expectations of your sessions at Asula?

THE FOLLOWING TREATMENTS ARE OFFERED AT ASULA, PLEASE (CIRCLE) ANY OF INTEREST TO YOU.

CHIROPRACTIC **NATUROPATHY** **MASSAGE** **ACUPUNCTURE**

Patient Signature: _____ Date: _____

♥ WELCOME TO OUR CLINIC ♥