NEW PATIENT INTAKE FORM

asula
back·body·balance

Patient Information

Name:

Birthday: Gender Pronoun: ☐ He ☐ She ☐ They ☐ Other Age:

Address:

City: State: Zip:

E-mail Address:

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

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

Employer: Occupation:

Emergency Contact: Phone:

Primary Care Doctor: Phone:

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

Are you currently pregnant? ☐ YES ☐ NO

*If **"YES"** when is your due date?*

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?

Do you have any of the following today?

☐ Skin Rash ☐ Bruises ☐ Open Cuts ☐ Cold/Flu

Are there any areas you do not want to receive work in? Please list:

Are there any past experiences in your patient history that make you uncomfortable with touch? ☐ YES ☐ NO

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

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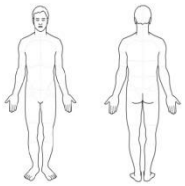
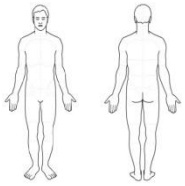
Areas of Complaint

PLEASE MARK ON THE DIAGRAM *to indicate any area(s) where you are currently experiencing discomfort.*



1.			☐ Constant	75-100% of awake time
☐ Right	☐ Left	☐ Bi-Lateral	☐ Frequent	51-75% of awake time
Date of initial onset:			☐ Intermittent	26-50% of awake time
Most recent episode onset:			☐ Occasional	0-25% of awake time



2.			☐ Constant	75-100% of awake time
☐ Right	☐ Left	☐ Bi-Lateral	☐ Frequent	51-75% of awake time
Date of initial onset:			☐ Intermittent	26-50% of awake time
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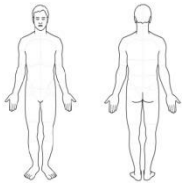

3.			☐ Constant	75-100% of awake time
☐ Right	☐ Left	☐ Bi-Lateral	☐ Frequent	51-75% of awake time
Date of initial onset:			☐ Intermittent	26-50% of awake time
Most recent episode onset:			☐ Occasional	0-25% of awake time

SYMPTOM CHANGES

- ☐ Worse in the morning
- ☐ Worse in the afternoon
- ☐ Worse in the evening
- ☐ Changes with the weather
- ☐ It does not change

SYMPTOM RELIEF

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

SYMPTOM AGGRAVATORS

- ☐ Sitting
- ☐ Standing
- ☐ Laying down
- ☐ Movement
- ☐ Immobility
- ☐ Other

Pre-Existing & Family History

Please ☑ the box that applies to each condition listed below. If a family member has had the condition, please ☑ the FAMILY box.

FAMILY	PAST	PRESENT	NEVER		FAMILY	PAST	PRESENT	NEVER	
☐	☐	☐	☐	Osteoarthritis	☐	☐	☐	☐	Stroke
☐	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐	☐	Cancer
☐	☐	☐	☐	Diabetes	☐	☐	☐	☐	Disc problems or spinal injuries
☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐	Osteoporosis / Osteopenia
☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	Scoliosis
☐	☐	☐	☐	Heart attack	☐	☐	☐	☐	Auto-Immune Condition (AIDS, Fibromyalgia, Chronic Fatigue, Lupus, etc.
☐	☐	☐	☐	Heart condition	☐	☐	☐	☐	Thyroid disorder

Please list name of family member who has had any marked conditions above:

Medical History (please list any...)

SURGERIES:	☐ YES ☐ NO	**SERIOUS INJURIES OR ILLNESSES:**	☐ YES ☐ NO
HOSPITALIZATIONS:	☐ YES ☐ NO	**MRI, X-RAY, CT SCANS, NERVE STUDIES:**	☐ YES ☐ NO

CURRENT MEDICATIONS & SUPPLEMENTS

Please list and include reason for using medication.

Review of Symptoms

Please ☑ the box that applies to each symptom/condition listed.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Unexplained fever	☐	☐	Eczema	☐	☐	Urine retention
☐	☐	Fatigue	☐	☐	Psoriasis	☐	☐	Increased urinary frequency
☐	☐	Loss of appetite	☐	☐	Sinus infections	☐	☐	Excessive thirst
☐	☐	Unexpected weight gain/loss	☐	☐	Allergies	☐	☐	Insomnia
☐	☐	Numbness	☐	☐	Asthma	☐	☐	Anxiety
☐	☐	Tingling	☐	☐	Shortness of breath	☐	☐	Depression
☐	☐	Muscle Weakness	☐	☐	Chest pain	☐	☐	Menstrual problems
☐	☐	Decreased coordination	☐	☐	Heart palpitations	☐	☐	Sprain/strain
☐	☐	Difficulty controlling bowel/bladder	☐	☐	Varicose veins	☐	☐	Bursitis
☐	☐	Fainting	☐	☐	Blood clots	☐	☐	Tendonitis
☐	☐	Seizures	☐	☐	Easy bruising	☐	☐	Fractures
☐	☐	Headaches/Migraines	☐	☐	Abdominal pain	☐	☐	Neuropathy
☐	☐	Dizziness	☐	☐	Bloating	☐	☐	Traumatic brain injury
☐	☐	Vision changes	☐	☐	Nausea/vomiting	☐	☐	Whiplash
☐	☐	Tinnitus	☐	☐	Constipation/Diarrhea	☐	☐	

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

Patient Signature: _____ Date: _____

♥ WELCOME TO OUR CLINIC ♥