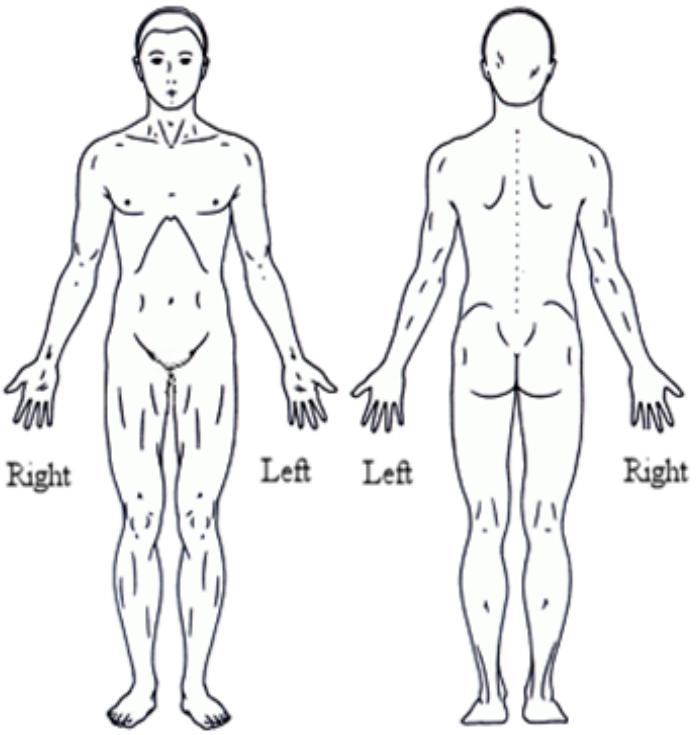
fit spa
PERFORMANCE THERAPY

New Patient Chiropractic Intake Form

Date _____

Name			Phone/Email	
Address				City/State/Zip
Date of Birth / /	Social Security #		Driver's License #	
Age	Weight	Height	Sex ☐ M ☐ F ☐ Other	Marital Status ☐ S ☐ M ☐ D ☐ W
Occupation Employer			Work Phone	
Insurance Company			Insurance Company Phone	
Insured's Name			Insured's Date of Birth	
Insured's ID #			Group ID #	
Primary Care Physician			Physician Phone	
Primary Care Physician Address				
How did you hear about us? If by Referral, please name.				

CASE HISTORY



Using the symbols below, mark on the picture where you feel your symptoms.

○ Numbness	N
○ Dull Ache	D
○ Burning	B
○ Sharp/Stabbing	S
○ Pins/Needles	P
○ Shooting/Radiating	R
○ Other	X

Please circle degree of pain, "0" being none, "10" being worst possible pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **WORST POSSIBLE PAIN**

Present condition due to an injury? ☐ Yes ☐ No ☐ On the Job? ☐ Auto Accident? ☐ Other?_____
Reason for seeking care/Location of Pain
Are the symptoms constant, or do they come and go? ☐ Constant ☐ Come and Go
What caused these symptoms?
Since it began, is this Condition: ☐ Better ☐ Worse ☐ Same
Is this condition interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other
Is this condition worse during certain times of the day? ☐ Yes ☐ No When?
List any other doctors seen for this
List any diagnosis and type of treatment
When did your symptoms begin?
Do you consider this condition to be severe?
What activities aggravate your condition/pain?
What activities lessen your condition/pain?
What concerns you most about your problem?
Have you had similar symptoms or injuries before? ☐ Yes (Explain) ☐ No

PREVIOUS AND FAMILY HISTORY

Any other symptoms or health problems?

How do you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What kind of regular exercise do you perform?

How often?

☐ 1-2x/week ☐ 3-4x/week ☐ 5+x/week

Health Conditions of Biological Family Members ☐ Unknown

Father/Paternal Grandparents	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Mother/Maternal Grandparents	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Brother(s) / Sister(s)	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Cause of Death of Biological Family Members ☐ Unknown

Are you currently taking medication? ☐ Yes ☐ No

List Current & Past Medications

Do you take Vitamins/Supplements? ☐ Yes ☐ No

If yes, type and how often:

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, explain:

List the approximate dates of any previous surgeries, hospitalizations or treated conditions not listed above:

What types of activities do you routinely do at work?

☐ Standing ☐ Sitting ☐ Driving ☐ Lifting ☐ Computer Work ☐ Phone calls ☐ Travel

What types of activities do you routinely do outside of work?

Have you or any relative received chiropractic treatment previously? ☐ Yes ☐ No

If yes, how long ago? What were the results? ☐ Great ☐ Good ☐ Fair ☐ Poor

Sports/Other injuries? ☐ Yes ☐ No Car Accident(s)? ☐ Yes ☐ No

If yes, _____ If yes, _____

Do you smoke? ☐ Yes (Packs/Day_____) ☐ No

Alcohol? ☐ Yes ☐ No Frequency? ☐ Daily ☐ Weekly

Caffeinated drinks per day? Hours/Day at a computer?

Do you sleep well? ☐ Yes ☐ No Approximate hours slept per night?

Sleeping posture? ☐ Side ☐ Stomach ☐ Back

On a scale of 1-10, how would you rate your current level of stress?

Is there anything else that you think we should know?

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS	EAR/NOSE/THROAT	CARDIO-VASCULAR
○ Convulsions	○ Earache	○ High Blood Pressure
○ Dizziness	○ Ear Noises	○ Heart Attack
○ Fainting	○ Enlarged Thyroid	○ Pain over Heart
○ Headache	○ Frequent Colds	○ Poor Circulation
○ Nervousness	○ Hay Fever	○ Heart Trouble
○ Numbness	○ Nasal Blockage	○ Rapid Heart
○ Fatigue	○ Nose Bleeds	○ Slow Heart
○ Anxiety	○ Pain Behind Eyes	○ Strokes
○ Depression	○ Poor Vision	○ Swelling Ankle
○ Irritability	○ Sinusitis	○ Varicose Veins
○ Insomnia/Disturbed Sleep	○ Sore Throats	○ Cold Hands/Feet
○ Other:	○ Tonsillitis	○ Other:

GENITO-URINARY	SKIN OR ALLERGIES	RESPIRATORY
○ Blood in Urine	○ Boils	○ Asthma
○ Frequent Urination	○ Bruising Easily	○ Chronic Cough
○ Kidney Infection	○ Dryness	○ Difficulty Breathing
○ Painful Urination	○ Eczema/Rash/Dermatitis	○ Spitting Blood
○ Prostate Problems	○ Hives	○ Spitting Phlegm
○ Loss of Bladder Control	○ Itching	○ Wheezing
	○ Sensitive Skin	○ Other:
	○ Allergy:	

MUSCLES & JOINTS	GASTRO-INTESTINAL	FOR WOMEN ONLY
○ Low Back Problems	○ Belching/Gas	○ Birth Control
○ Pain between Shoulders	○ Colon Problems	○ Hormone Replacement
○ Neck Problems	○ Constipation	○ Cramps/Backaches
○ Arm Problems	○ Diarrhea	○ Excessive Flow
○ Leg Problems	○ Excessive Hunger	○ Hot Flashes
○ Swollen Joints	○ Excessive Thirst	○ Irregular Cycle
○ Painful Joints	○ Gall Bladder Trouble	○ Miscarriage
○ Stiff Joints	○ Hemorrhoids	○ Painful Periods
○ Sore Muscles	○ Liver	○ Vaginal Discharge
○ Weak Muscles	○ Nausea	○ Breast Pain
○ Walking Problems	○ Abdominal Pain	○ Infertility
○ Sprains/Strains	○ Ulcer	○ Pregnant at this Time Y N
○ Broken Bones	○ Poor Appetite	
	○ Poor Digestion	
	○ Vomiting	
	○ Vomiting Blood	
	○ Black Stool	
	○ Bloody Stool	
	○ Weight Loss/Gain	

Fit Spa Services You're Interested In:

○ Chiropractic	○ Acupuncture	○ Massage Therapy
○ Muscle Activation	○ Postural Correction	○ Neuromuscular Reeducation
○ Detoxification	○ Weight Loss	○ Nutrition/Supplementation

New Patient Acknowledgment

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

_____

Patient Name (please print)

_____

Patient Signature

_____

Date