REGISTRATION & HISTORY

Date ____________________

Welcome to our office!

Please fill out this Confidential Client Intake Form as **thoroughly** as possible.

CLIENT INFORMATION

Client ____________________

Address ____________________

____

City State Zip

Primary Phone (Home/Work/Cell) ____________________

Secondary Phone (Home/Work/Cell) ____________________

Best time and number to reach you at ____________________

Sex: ☐ M ☐ F Age ____ Date of Birth ____________________

☐ Single ☐ Married ☐ Other

Email ____________________

Employer ____________________

Employer Address ____________________

____

City State Zip

Employer Phone ____________________ ext. __________

Occupation ____________________

Number of hours worked per week ____________________

How did you hear about us? ____________________

IN CASE OF EMERGENCY, CONTACT

Name ____________________

Relationship ____________________

Phone ____________________

PRIMARY CARE PHYSICIAN

Name ____________________

Address ____________________

____

Phone ____________________ Fax ____________________

Date Last Seen ____________________

ACCIDENT INFORMATION Complete if injury is due to an accident

Is client injury related to:

☐ employment ☐ auto accident State ________

☐ other accident ☐ crime (Only for Medicaid)

Attorney Name (if applicable) ____________________

Address ____________________

INSURANCE Complete if you want to submit for reimbursement

We are sorry for any inconvenience however we do not accept Medicare Clients.

Who is the **Primary Card Holder**? ____________________

Relationship to client ____________________

Address (if different from client) ____________________

____

City State Zip

Phone number (if different from client) ____________________

Date of Birth of Primary Card Holder ____________________

ID Number ____________________ Group # ____________________

Insurance Co. ____________________

Is client covered by additional insurance? Yes No

Who is the **Secondary Card Holder**? ____________________

Relationship to client ____________________

Address (if different from client) ____________________

____

City State Zip

Phone number (if different from client) ____________________

Date of Birth of Secondary Card Holder ____________________

ID Number ____________________ Group # ____________________

Insurance Co. ____________________

Client is financially responsible for all charges whether or not reimbursed by insurance.

MEDICATIONS

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

VITAMINS / HERBS / SUPPLEMENTS

____________________ ____________________

____________________ ____________________

____________________ ____________________

ALLERGIES

____________________ ____________________

____________________ ____________________

Schaffstall CHIROPRACTIC

Client Name ______________________________ Date ______________

CLIENT CONDITION

Reason for visit ____

When did your symptoms appear? __________________________ How did this happen? ______________________________

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown

How often do you have this pain? ____________________ Is it constant or does it come and go? ______________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other

What treatment have you already received for your condition? ☐ Medical ☐ PT ☐ Chiropractic ☐ None ☐ Other _____

Name of other doctor(s) who have treated you for your condition ____

Suspected or known diagnosis of your condition ____

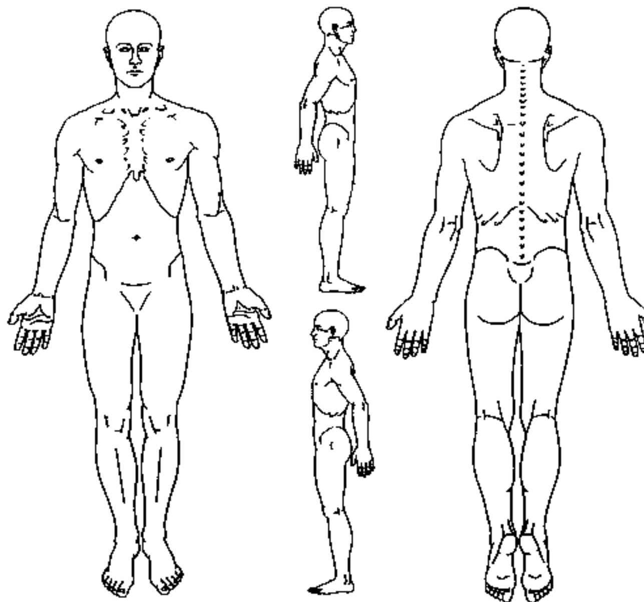
PAIN ASSESSMENT

Type of Pain

☐ Sharp
☐ Dull
☐ Throbbing
☐ Aching
☐ Shooting
☐ Cramps
☐ Stiffness
☐ Swelling
☐ Numbness
☐ Burning
☐ Tingling
☐ Pressure
☐ Other _____

Pain Diagram

On the diagram below, please indicate where you are experiencing pain or other symptoms right now.



Pain Scale

Please rate the severity of your pain on a scale from 0 to 10

Worst pain imaginable
10
9
8
7
6
5
4
3
2
1
0
No pain

GOALS

What are your goals for coming here ____

____

PAST INJURIES / SURGERIES

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Joint Replacements		

Schaffstall CHIROPRACTIC

Client Name ______________________ Date ____________

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ________

HEALTH HISTORY

Have you had any of the following in the past 6 months or is a chronic issue:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐	☐	Eating Disorder	☐	☐	Liver Disease	☐	☐	Rheumatic Fever	☐	☐
Alcoholism	☐	☐	Emphysema/COPD	☐	☐	Measles	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Epilepsy	☐	☐	Menstrual Problems	☐	☐	Sinus/Allergies	☐	☐
Appendicitis	☐	☐	Fatigue	☐	☐	Mental Illness	☐	☐	Sleep Problems	☐	☐
Arthritis	☐	☐	Fibromyalgia	☐	☐	Miscarriage	☐	☐	Stomach Ulcers	☐	☐
Asthma	☐	☐	Fractures	☐	☐	Mononucleosis	☐	☐	Stroke	☐	☐
Bladder Trouble	☐	☐	Gas	☐	☐	Multiple Sclerosis	☐	☐	Thyroid Problems	☐	☐
Bleeding Disorder	☐	☐	Goiter	☐	☐	Mumps	☐	☐	Tuberculosis	☐	☐
Bloating	☐	☐	Gout	☐	☐	Nervousness	☐	☐	Tumors, Growths	☐	☐
Breast Lump	☐	☐	Headaches/Migraine	☐	☐	Osteoporosis	☐	☐	Typhoid Fever	☐	☐
Bronchitis	☐	☐	Heart Disease	☐	☐	Pacemaker	☐	☐	Urinary Tract Infection	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Parkinson's Disease	☐	☐	Vaginal Infections	☐	☐
Chemical Dependency	☐	☐	Hernia	☐	☐	Pinched Nerve	☐	☐	Weight Trouble	☐	☐
Chicken Pox	☐	☐	Herniated Disk	☐	☐	Pneumonia	☐	☐	Whooping Cough	☐	☐
Constipation	☐	☐	Herpes	☐	☐	Polio	☐	☐	Other ________		
Depression/Anxiety	☐	☐	High Blood Pressure	☐	☐	Prostate Problem	☐	☐	________		
Diabetes	☐	☐	High Cholesterol	☐	☐	Prosthesis	☐	☐	________		
Diarrhea	☐	☐	Irritability	☐	☐	Ringing in Ears	☐	☐	Are you pregnant	☐	☐
Dizziness	☐	☐	Kidney Disease	☐	☐	Rheumatoid Arthritis	☐	☐	If Yes, Due Date ________		

FAMILY HISTORY (Check all those that apply)

	Father	Mother	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother	Brother(s) / Sister(s)	Spouse	Children		
Age (or Age at death)											
Health (G=good, F=fair, P=poor)											
Cause of Death											
Arthritis											
Asthma											
Back Problems											
Cancer											
Circulatory Problems											
Diabetes											
Emphysema / COPD											
Headaches											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Kidney Disease											
Osteoporosis											
Sinus Problems / Allergies											
Stroke											
Thyroid Problems											
Ulcer or Stomach Problems											
Other											