515-987-0767

New Patient Intake Form

Name ___________________________________ Age________ Date of Birth ___/___ / _____

Address ____
Street   City   State   Zip

Phone (Home) ________________ (Work) ________________ (Cell) _________________

E-Mail Address ____

Social Security Number: ______ - ____ - ______   Gender   M   F

Marital Status: Single   Married   Wid.   Div.   Spouse's Name ___________________

Emergency Contact Name/Relation ______________________ Phone #: _________________

How many children? _____ Names & Ages: _______________________________________

Employer: ____

Who is your primary doctor? ____

Clinic Name: ____________________________________ Phone #: ________________

How did you find out about Enhanced Health Chiropractic?

○ Referred by: ________________________   ○ DSM Register   ○ Health Talk

○ Community Greetings Visit   ○ Chamber of Commerce (WDM, Waukee, or Clive)

○ Other: ______________________________

Are you here because you were involved in a:

__ Motor Vehicle Collision ___ Work Place Injury ___ Accident at home___ None of these

Are you planning to use health insurance to supplement payment to our office?   Y   N

Type of insurance:

__ Health plan (employee or personal) __ Health Savings Account____Medicare __ Personal Injury

________________________________   ________________   _____________________
Primary Ins. Company   Primary Ins. ID#   Primary Ins. Group #

________________________________   ________________   _____________________
Secondary Ins. Company   Secondary Ins. ID#   Secondary Ins. Group #

Insured's Information   ___ Patient is the insured

Name ___________________________________ Age________ Date of Birth ___/___ / _____

Address ____
Street   City   State   Zip

SSN: _______-_____-________   Gender M F   Employer: ________________________

Relationship to patient: ____Self __ Spouse __ Dependent ___Other: __________________

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Health History

Please describe what brought you into the office today ____________________________________

____

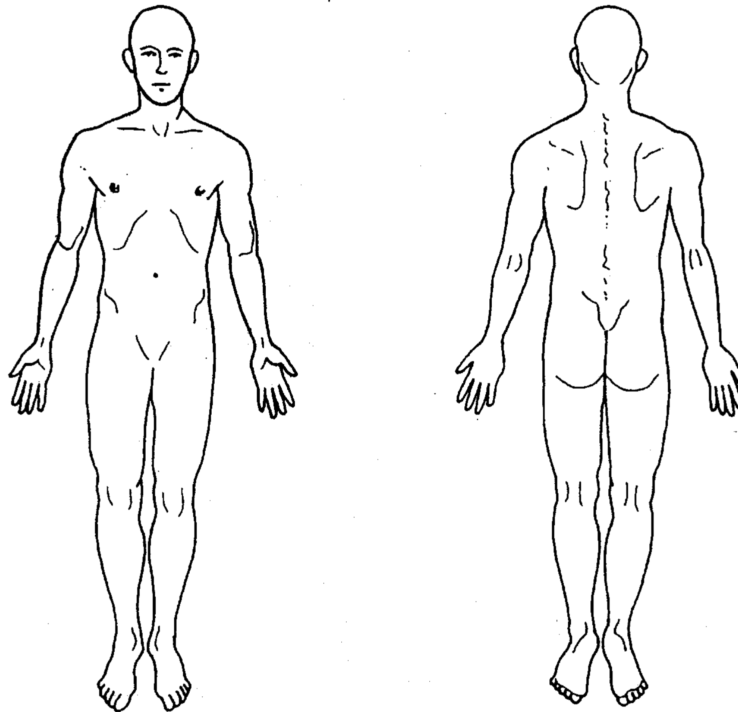
____

On a scale of 1-10, 1 being "No pain or discomfort," 6 being "Pain that limits my work schedule," and 10 being "Pain that causes thoughts of suicide" how would you rate your pain:

NOW:_____ /10 At its WORST:_____ /10 At its BEST:_____ /10 AVERAGE: _____ /10

On the following picture, please mark the areas on your body where you feel pain or other issues. Please use the key below to describe the type of pain.

A - Ache **B** - Burning **N** - Numbness **S** - Stabbing **T** - Throbbing **P** - Pins & Needles



If you have no pain please check here: _______

What needs to happen for you to consider your treatment plan a success?____________________

____

Have you ever consulted a Chiropractor before? Y N If yes, who? ________________________

When? _______________Why? _____________________________For how long? ______________

When was the last time any of the following tests were ordered, and by whom?

X-rays? _______________MRI?_____________ Blood panel? ____________ Other? ___________

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Do you now, or have you ever suffered from: (please mark "N" for now or "P" for past)

____Neck Pain	____Low Back Pain	____Headaches	____ Dizziness
____Asthma	____Diabetes	____Arthritis	____ High Blood Pressure
____Allergies	____Lung problems	____Neuritis	____ High Cholesterol
____Depression	____Mood Disorder	____Irritability	____ Menstrual Pain/Difficulty
____Heart Burn	____Heart trouble	____Poor Circulation	____ Sinus trouble
____Cancer	____Nervousness	____Anemia	____ Digestive disorder
____Anxiety	____Trouble Sleeping	____Tumor	____ Numbness in Hands/Feet
____Low Energy	____Tire Easily	____TB	____ Tingling in Hands/Feet

Please list any other health concerns you have at this time:___________________________________

____

Has anybody in your immediate family (last two generations) had any of the following conditions, either currently or previously? Please indicate relationship.

________Diabetes	__________ Stroke	__________Kidney Problem	__________Heart Problems
________Cancer	__________ Obesity	__________Headaches	__________Out of Shape

________Other conditions: ____

I am interested in the following:

__ Decreasing Pain	__ Improving Balance	__Improving Posture	__ Increasing Strength
__ Changing Weight	__ Improving Diet	__Improving Flexibility	__ Improving Overall Health

List ALL past accidents/injuries: (include date of injury)

Vehicle Accidents: ____

Sports Injuries: ____

Childhood Injuries: ____

Broken Bones: ____

Other:____

Have you had any of the following surgeries/procedures: (please indicate year)

___ Back/Spine	___ Neck	___ Tonsillectomy	___ Hernia Repair
___ Gallbladder	___ Thyroid	___ Appendectomy	___ Stomach
___ Spinal injection	___ Tubes in ears	___ Female/Male surgery	___ No Surgeries

___ Any Other Surgeries: ____

Any Other Medical Procedures: ____

Activities of Daily Living:

Please describe the type of work you do on a daily basis: ______________________________

____

Do you use tobacco? Y N Have you ever? Y N How many packs per day? ______

How many servings of pop do you drink per day? __ 0 __ 1-2 __ 3-4 __ ≥5

How many servings of coffee do you drink per day? __ 0 __ 1-2 __ 3-4 __ ≥5

How many servings of alcohol do you drink per day? __ 0 __ 1-2 __ 3-4 __ ≥5

How many glasses of water do you drink per day? __ 0 __ 1-2 __ 3-4 __ ≥5

How many hours per day do you spend: Driving: ___<1 ___1-3 ___3-5 __ >5

TV: ___<1 __ 1-3 __ 3-5 __ >5 Computer: ___<1 ___1-3 ___3-5 __ >5

How many servings of each of the following foods do you eat per day?

Veggies: ___<1 __ 1-3 __ 3-5 __ >5 Meat: ___<1 ___1-3 ___3-5 __ >5

Fruits: ___<1 __ 1-3 __ 3-5 __ >5 Dairy: ___<1 ___1-3 ___3-5 __ >5

Carbs: ___<1 __ 1-3 __ 3-5 __ >5 Sweets: ___<1 ___1-3 ___3-5 __ >5
(Breads & Pastas)

Do you drink diet sodas or eat sugar-free food? Y N
Do you take any drugs, supplements or vitamins? Y N
If Yes, please fill out Drug & Supplement Record

Do you exercise? Y N How long do your workouts last? ______________________

How often do you exercise? __ ≥5x/week __3-4x/week __ 1-2x/week __ <1x/week

What do you do while exercising? (mark all that apply)

__ Running ___Swimming __ Abs __Stretching/flexibility
__ Walking ___Yoga/Pilates __ Weight lifting __Resistance bands
__ Stairs ___Group classes __ Rock Climbing __Other: ________________

For Women Only:

Are you currently pregnant? Y N Unsure Date last period began: ____________________
Do any of the following pertain to you?

___Tubal ligation ___ Hysterectomy (comp/partial) ___ Birth Control Pills __ Partner vasectomy

Thank you for taking the time to completely fill out this paperwork. Dr. Tom will review your information and then begin your consultation. If you have any questions while completing these forms please ask.

Enhanced Health Chiropractic, P.C.
9350 University Ave #114
West Des Moines, IA 50266
515-987-0767 (office)
888-504-5490 (fax)
EHChiro@gmail.com

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