



Gonstead Family Chiropractic

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ Date ____/____/____ S/S ____ - ____ - ____
First MI Last

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date ____/____/____ Height _____ Weight _____ e-mail address: _____

Sex: Female Male Status: Minor Married Single Other

Your Employer _____ Occupation _____

Business Address _____ City _____ State ____ Zip _____

Spouse/ Parent's Name _____ Phone _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency _____ Phone _____

HEALTH HISTORY

Do you currently have or have you previously had any of the following symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tension | <input type="checkbox"/> Ringing/ Buzzing in Ears |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Menstrual Pain |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Light Sensitivity with Eyes | <input type="checkbox"/> Hot flashes |

Have **YOU** (check) or **A FAMILY MEMBER** (check) ever been diagnosed with any of the following conditions:

- | | | |
|--|---|--|
| <input type="radio"/> <input type="checkbox"/> AIDS/HIV | <input type="radio"/> <input type="checkbox"/> Cancer | <input type="radio"/> <input type="checkbox"/> High Blood Pressure |
| <input type="radio"/> <input type="checkbox"/> Heart Disease | <input type="radio"/> <input type="checkbox"/> Diabetes | <input type="radio"/> <input type="checkbox"/> Stroke |
| <input type="radio"/> <input type="checkbox"/> None | <input type="radio"/> <input type="checkbox"/> Unknown | <input type="radio"/> <input type="checkbox"/> Other _____ |

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

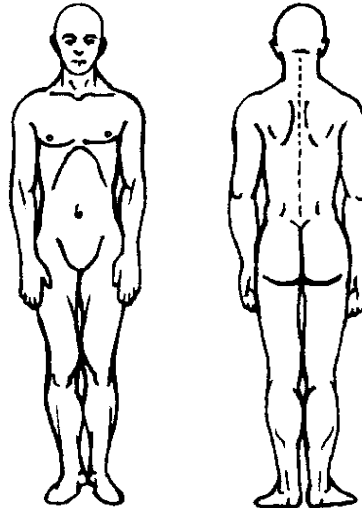
(chief complaint)

1) _____ 2) _____ 3) _____ 4) _____
0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = !!!
- Shooting = XXX
- Other = ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Please describe any other activities that are restricted due to this injury? _____

When did you first notice these symptoms? _____ Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you had an injury or fall? No Yes, Describe _____

Have you ever been diagnosed with a Subluxation? No Yes, When? _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: None

Surgical History: _____ None

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

DATE: ____/____/____ SIGNATURE: _____

PARENT/ GUARDIAN: _____