Dunn Chiropractic & Rehab
1530 N Bridge St
Chillicothe, OH 45601
740-773-5858

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Personal Information

*First Name: _____
Middle Name: _____
*Last Name: _____
*Gender: ○ Female ○ Male
*Date of Birth: _____
Social Security #: ___ ___ ____
Height: ▼ Feet ▼ Inches
Weight: _____
Marital Status: ▼
Spouse's Name: _____
Number of Children: ▼

Emergency Contact: _____
Relationship: _____
Phone: _____

Contact Information

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

*Home Phone: _____
Cell Phone: _____
Work Phone: _____

Country: United States ▼
Address Line 1: _____
Address Line 2: _____
City: _____
State/Province/Region: ▼
*Zip/Postal Code: _____

How did you find out about our office?

Referring Physician: _____
Referring Patient: _____
Referred by: ▼

Did you hear about our office from an advertisement?

○ No ○ Yes

If Yes, Where:

Did you hear about our office from a phone or professional directory?

○ No ○ Yes

If Yes, Where:

Employment Information

Regular Work Status:

Employer Name:

Employer Address:

Employer City:

Employer State:

Employer Zip:

Occupation:

Supervisor Name:

Supervisor Phone/Extension:

Physical Work Duties:

What is the purpose of your visit?

○ Wellness ○ Complaint ○ Injury ○ Other

Current Symptoms

Where did the injury occur?

○ Automobile ○ Work ○ 3rd Party Premises ○ Other

Date of Injury:

Please Describe how the injury, pain, or discomfort originated:

Please describe your pain/discomfort:

Select frequency you experience pain from this condition:

○ Always ○ Hourly ○ Daily ○ Occasionally

Does this condition interfere with any of your daily activities or routines?

○ No ○ Yes

Has this condition affected your quality of sleep or ability to sleep?

No Yes

Has this condition affected your appetite?

No Yes

If Yes, Explain:

Have you missed any work due to this injury?

No Yes

If yes:
Select unable to work from date:
Select day you have or will return to work:

Have you reduced or limited your work hours because of this condition?

No Yes

If Yes, Explain:

Is the pain/discomfort worse at certain times of the day?

No Yes

If Yes, Explain:

Does the weather affect your pain/discomfort?

No Yes

If Yes, Explain:

List anything that aggravates your condition:

List anything that relieves or improves your condition:

Have you received professional treatment for this condition?

No Yes

If Yes, Explain:

Have you had X-rays taken for this condition?

No Yes

If Yes, Where?

Pain level Rating - Scale 1 to 10 (Where 1 is least pain and 10 is maximum pain)

At its best: ▼ At its Worst: ▼

Current Level: ▼

Have you ever had this same condition?

○ No ○ Yes

If Yes, When?:

List other practitioners seen for this injury/condition:

Insurance & Payment for Care

How do you plan to pay for care?

○ Personal Insurance ○ Third-Party Insurance ○ No Insurance, Self-Pay

Name of Party Responsible for Payment:

Responsible Party Phone:

Primary Insurance

Insurance Name:
Phone:
Address:
City:
State: ▼
Zip:
ID/Policy #:
Group #:
Insured's Name:
Insured's Date of Birth:

Secondary Insurance

Insurance Name:
Phone:
Address:
City:
State: ▼
Zip:
ID/Policy #:
Group #:
Insured's Name:
Insured's Date of Birth:

If an auto accident, please provide:

Claim #:

Insurance Contact Person:

Insurance Phone:

Attorney's Full Name:

Attorney's Phone:

Personal Health History

Family/Primary Physician

Date of Last Physical Exam:

Name of Family Physician or Physician Seen: _____

Physician Phone: _____

Physician City: _____

Physician State: ▼

Physician Zip: _____

Please list any health conditions that you have been treated for in the last year:
(condition, cause, current/resolved)

Separate details with "," comma as shown above.

Have you had previous chiropractic care?

No Yes

Condition(s) treated:

Date of last chiropractic visit:

Are you pregnant, or have you had any signs of pregnancy? (Female Only)

No Yes

Are you planning to get pregnant in the next 12 months? (Female Only)

No Yes

List current medications:
(name, amounts, frequency, length of use, reason for use)

Separate details with "," comma as shown above.

List current vitamins, minerals, supplements, or herbs:
(name, amounts, frequency, length of use, reason for use)

Separate details with "," comma as shown above.

Personal Incident History:

Broken Bones?

Had Major Sprains/Strains?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Been Hospitalized?

No Yes

Briefly Explain: _____

Been In Auto Accident?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Been Diagnosed with an Eating Disorder?

No Yes

Briefly Explain: _____

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Had Surgery?

No Yes

Briefly Explain: _____

Been Struck Unconscious?

No Yes

If yes:
Did you get professional care/treatment?
No Yes

Briefly Explain: _____

Had a Stroke?

No Yes

Briefly Explain: _____

Family Health History

Please list diagnosed health conditions and untimely deaths.(condition, relationship to you)
(Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)

Separate details with "," comma as shown above.

(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Social History & Life Choices:

Alcohol

Daily Weekly Occasionally Never

Diet Food Products

Caffeine Drinks & Products

Daily Weekly Occasionally Never

Drugs

Daily Weekly Occasionally Never

Energy Products or Over-the-Counter Stimulants

Daily Weekly Occasionally Never

Fresh & Homemade Foods

Daily Weekly Occasionally Never

Soft Drinks

Daily Weekly Occasionally Never

Water

Daily Weekly Occasionally Never

Daily Weekly Occasionally Never

Exercise

Daily Weekly Occasionally Never

Preprocessed, Packaged, & Restaurant Food

Daily Weekly Occasionally Never

Tobacco

Daily Weekly Occasionally Never

Chiropractic Experience

Who referred you to our office?

Where did you hear about us?…

Please select all that apply.

Newspaper Sign Yellow Pages Community Event Mailing Other

Other:

Have you been adjusted by a chiropractor before?

Yes No

If yes…

What was the reason for those visits?

Doctor's Name:

Approximate date of last visit:

Has any member of your family ever seen a wellness chiropractor?

Yes No

Reason for this Visit

Describe the reason for this visit

Please briefly describe, including the impact it has had on your life.

If you're only here for chiropractic wellness services please skip this section.

○ Wellness ○ Sports ○ Auto ○ Fall ○ Home Injury ○ Job ○ Chronic Discomfort ○ Other

Briefly Explain:

_____

When did this concern begin?

_____

Has this concern:

○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain:

_____

Has this concern occured before?

○ Yes ○ No

Briefly Explain:

_____

Have you seen other doctors for this concern?

○ Yes ○ No

Doctor's Name:

_____

Type of Treatment:

_____

Results: ○ Good ○ Bad ○ Indifferent

For Women Only

COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A WOMAN OVER 16 YEARS OF AGE.

Are you pregnant?

○ No ○ Yes

Are you nursing?

○ No ○ Yes

Are you taking birth control?

○ No ○ Yes

Do you experience painful periods?

No Yes

Do you have irregular cycles?

No Yes

Do you have breast implants?

No Yes

Do you perform a regular self breast examination?

No Yes

Do you take hormone replacement therapy (HRT)?

No Yes

Do you take oral contraceptives?

No Yes

Estimate the date of your most recent PAP/pelvic exam:

_____

Date of last mammogram?

_____

Date of Last Menstrual Period?

_____

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ ***I want the Doctor to select the type of care appropriate for my condition.***

☐ **Relief care:** Symptomatic relief of pain or discomfort.

☐ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.

☐ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Were You Aware That...

Doctors of Chiropractic work with the nervous system?

No Yes

The nervous system controls all bodily functions and systems?

No Yes

Chiropractic is the largest natural healing profession in the world?

No Yes

Health Problems & Concerns:

Please select all that you have had or currently have.

☐ Allergies	☐ Dizziness	☐ Pacemaker
☐ Alcoholism	☐ Epilepsy	☐ Parkinson's
☐ Anemia	☐ Excessive Menstruation	☐ Polio
☐ Arteriosclerosis	☐ Eye Pain or Difficulties	☐ Poor Posture

- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Pain
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] CHF (congestive heart disease)
- [ ] Cold Extremities
- [ ] Constipation
- [ ] COPD/emphysema
- [ ] Cramps
- [ ] CVA (stroke/TIA)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Diagnosed emotional/mental disorders
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder disease/stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver disease/cirrhosis
- [ ] Loss of Memory
- [ ] Loss of Balance
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung disease
- [ ] Macular Degeneration
- [ ] Migraines
- [ ] Nosebleeds
- [ ] Prostate Trouble
- [ ] Retinal Disease
- [ ] Sciatica
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Sleep Problems/Insomnia
- [ ] Skin Sensitivity
- [ ] Smoked
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other

Other:

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- [ ] Myocardial infarction
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Bypass surgery
- [ ] Coronary artery disease

Do you have Diabetes? If so what type?

- ○ Type I
- ○ Type II
- ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

Worker's Compensation

Who saw the accident? Title:

Who reported the accident? Title:

Type of windows: Type of shop:

Do you use hand or foot levers? ○ Yes ○ No Do you work overhead? ○ Yes ○ No

Are you tired when you go home? ○ Yes ○ No

Describe the accident?

Do you lift from?

Ground Bench Platform Box Pallet Other

Do you have to reach?

Yes No Explain:

Is your work area cluttered?

Yes No Explain:

Do you push or pull?

Yes No Explain:

Do you pick up or lift?

Yes No How Much: How Often:

Do you lift in and out of a machine?

Yes No If so, do you:

Type of Floor:

If other describe:

Type of ventilation:

If other describe:

Type of lighting:

If other describe:

Is your work area:

If other describe:

Do you have any other jobs?

Yes No If yes, what type:

Has outside help been hired?

Yes No If yes, why:

Do you use a cart?

Yes No Type of Wheels:

Condition of cart: Good Bad Other If other, explain:

# of carts being moved at once: Weight moved per day:

From where to where:

Auto Accident

Date & Time: Make & Model:

Street / Location: # of persons in your vehicle

Were you the: Were you:

Speed of your vehicle: Speed of their vehicle:

Were you wearing a seat belt? ○ Yes ○ No

Have you worked since this injury? ○ Yes ○ No

Are your work activities restricted? ○ Yes ○ No

Were there any witnesses? ○ Yes ○ No

Did the vehicle have airbags? ○ Yes ○ No

Did the airbags inflate? ○ Yes ○ No

Did the police arrive? ○ Yes ○ No

Police report filed? ○ Yes ○ No

Visited a Hospital or Doctor?

○ Yes ○ No Name of hospital:

When did you go to the hospital? ▼

How did you get to the hospital? ▼

Was the Doctor a? ▼

Were any X-rays taken? ○ Yes ○ No

Medication prescribed? ○ Yes ○ No

Were you rendered unconscious?

○ Yes ○ No How long?

Traffic violation issued?

○ Yes ○ No To Whom?

Retained an attorney?

○ Yes ○ No Name: Phone:

In relation to the base of your skull, where was the headrest?

▼

Impact to your vehicle came from?

▼

The direction you were heading?

▼

The direction they were heading?

▼

The direction you were facing?

▼

What did your vehicle impact?

▼ Explain:

Strike anything in the vehicle?

▼ Explain:

Describe the accident?

How did you feel right after?

Names of all persons in this accident:

Electronic Health Record (EHR) Information

Preferred Language: ▼ Ethnicity: ▼

Race: ▼

Smoking Status: ▼

Type of Tobacco: ☐ Cigarettes ☐ Chewing Tobacco ☐ Cigar ☐ Pipe ☐ Other

Have you tried to quit? ○ Yes ○ No How much tobacco do you use? _____

How long have you used tobacco? _____

Current Medications And Dosage:

Medication Name	Dosage

Add Another Medication

Medication Allergies:

Medication Name	Reaction	Date Discovered

Add Another Medication Allergies

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ☐ **I agree with this statement of authorization**

Name of the Insured:
(Please Print) _____

Patient's/Guardian's signature: _____ **Date:** _____

Signature

Clear Signature