Select Chiropractic & Wellness
Carlsbad, CA

Chiropractic Patient Intake Form

www.selectchirowellness.com
(760) 893-6459

Confidential Patient Information

Patient's Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (C): _____ (H): _____ (W): _____
E-Mail Address: _____
Communication Preference: (circle one) Phone Call / Text Message / E-Mail / Mail

Date of Birth: _____ Age: ____
Social Security #: _____

Status: (circle one) Single / Married / Widowed
Separated / Divorced
If married, spouse's name: _____
# of children: _____

Occupation: _____ (circle one) Part-Time / Full-Time / Retired
Employer: _____

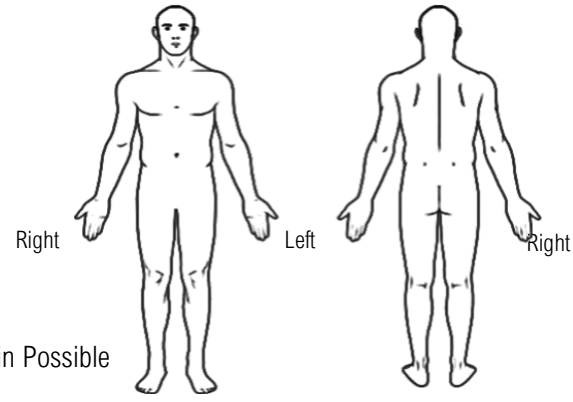
Primary Care Physician: _____ Phone: _____
_____ Please do not share the results of this visit with this provider
Whom may we thank for referring you to our practice? (circle one):
Friend/Family: _____ / Insurance / Internet Search / Yelp / Other: _____

Health History

Height: _____ ft _____ in Weight: _____ lb.
Have you recently gained weight unexpectedly? (circle one) Yes / No
Have you recently lost weight unexpectedly? (circle one) Yes / No

Main condition/symptom: _____
_____
Duration of condition/symptom: _____
Have you seen any other health care provider(s) for this? (circle one) Yes / No
If yes, who? When?
_____
_____

Draw the location of your pain on the face and/or body outlines.



Please make a slash through the line as to the level of your pain

No Pain |——————————————————————| Worst Pain Possible

Emily D. Mickle, DC, MSACN

Health History Continued

Allergies: Please list any allergies to medcations and foods that you have and your reactions

_____

_____

Surgeries: Please list the date(s) and surgical procedure(s) you've had

_____

_____

_____

Medications: Please list all prescriptions, over-the-counter medicines, and supplements

_____

_____

Injuries/Accidents: Please list any other injuries or accidents not described above

_____

_____

_____

Review of Body Systems (Circle if you currently HAVE, have HAD, or if you DENY any of the listed conditions)

Musculoskeletal

Arthritis	HAVE / HAD / DENY
Fracture	HAVE / HAD / DENY
Gout	HAVE / HAD / DENY
Implants/plates	HAVE / HAD / DENY
Osteoporosis	HAVE / HAD / DENY
Pins/screws	HAVE / HAD / DENY
Scoliosis	HAVE / HAD / DENY
TMJ issues	HAVE / HAD / DENY
Other: _____	

Neurological

Anxiety	HAVE / HAD / DENY
Depression	HAVE / HAD / DENY
Dizziness	HAVE / HAD / DENY
Epilepsy	HAVE / HAD / DENY
Headache	HAVE / HAD / DENY
Loss of smell	HAVE / HAD / DENY
Loss of taste	HAVE / HAD / DENY
Numbness	HAVE / HAD / DENY
Pins/needles	HAVE / HAD / DENY
Stroke	HAVE / HAD / DENY
Other: _____	

Head/ENT

Blurred vision	HAVE / HAD / DENY
Chronic ear ache	HAVE / HAD / DENY
Headaches	HAVE / HAD / DENY
Migraines	HAVE / HAD / DENY
Ringing in ears	HAVE / HAD / DENY
Other: _____	

Cardiovascular

Blood clots	HAVE / HAD / DENY
Easy bruising	HAVE / HAD / DENY
Heart attack	HAVE / HAD / DENY
Heart murmur	HAVE / HAD / DENY
High cholesterol	HAVE / HAD / DENY
Hypertension	HAVE / HAD / DENY
Hypotension	HAVE / HAD / DENY
Other: _____	

Respiratory

Apnea	HAVE / HAD / DENY
Asthma	HAVE / HAD / DENY
Pneumonia	HAVE / HAD / DENY
Other: _____	

Gastrointestinal

Disordered Eating	HAVE / HAD / DENY
Heartburn	HAVE / HAD / DENY
IBS	HAVE / HAD / DENY
Other: _____	

Genitourinary

Kidneystones	HAVE / HAD / DENY
Other: _____	

Endocrine

Diabetes	HAVE / HAD / DENY
If HAVE, Type I / Type II	
Hyperthyroid	HAVE / HAD / DENY
Hypothyroid	HAVE / HAD / DENY
Immune Disorders	HAVE / HAD / DENY
Metabolic Synd.	HAVE / HAD / DENY
Other: _____	

Dermatological

Skin sensitivity	HAVE / HAD / DENY
Other: _____	

Do you have any additional health conditions not listed above? If yes, please list below.

_____

_____

_____

Family Medical History

Does anyone in your immidiate family (father, mother, sibling, or offspring) have any of the following conditions? (circle one)

Heart Disease Yes / No If yes, who? _____
Hypertension Yes / No If yes, who? _____
Diabetes Yes / No If yes, who? _____ Type I / Type II
Cancer Yes / No If yes, who and what type? _____
Other Condition _____

Health Habits

Do you drink alcohol? (circle one) Yes / No
If yes, how many drinks per week? _____
Smoking history: Never / Former / Sometimes / Every day
If history of smoking, start date: _____ end date: _____
If current smoker, interest in quitting: None 1 2 3 4 5 6 7 8 9 10 Very Interested
Do you drink any beverages with caffeine? (circle one) Yes / No
If yes, which ones: (circle all that apply) Coffee / Tea / Soda / Other: _____
If yes, how many caffeinated beverages do you have a day? _____
Do you use any recreational drugs? (circle one) None / Former / Sometimes / Every day

How often do you exercise each week? (circle one)
Never / Once a week / A few times a week / Every other day / Daily
What types of exercise do you perform?

_____
_____

Use this space to write down any additional questions, comments, and/or concerns.

I certify to the best of my knowledge, the above information is complete and accurate.

Patient Signature _____ **Date:** _____

Select Chiropractic & Wellness
Carlsbad, CA

Functional Rating Index

www.selectchirowellness.com
(760) 893-6459

Patient's Name: _____ **Date:** _____

For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst pain possible
2. Sleeping	0 perfect sleep	1 Mildly distrubed sleep	2 oderately distrubed slee	3 Greatly distrubed sleep	4 Totally disturbed sleep
3. Personal Care (washing, dressing, etc.)	0 No pain; no restrictions	1 Mild pain; no restrictions	2 Moderate pain; need to go slowly	3 Moderate pain; need some assistance	4 Severe pain; need 100% assistance
4. Travel (driving, etc.)	0 No pain on long trips	1 Mild pain on long trips	2 Moderate pain on long trips	3 Moderate pain on short trips	4 Severe pain on short trips
5. Work	0 Can do usual work plus unlimited extra work	1 Can do usual work; no extra work	2 Can do 50% of usual work	3 Can do 25% of usual work	4 Cannot work
6. Recreation	0 Can do all activities	1 Can do most activities	2 Can do some activities	3 Can do a few activities	4 Cannot do any activities
7. Frequency of Pain	0 No pain	1 Occasional pain; 25% of the day	2 Intermittent pain; 50% of the day	3 Frequent pain; 75% of the day	4 Constant pain; 100% of the day
8. Lifting	0 No pain with heavy lifting	1 Increased pain with heavy weight	2 Increased pain with moderate weight	3 Increased pain with light weight	4 Increased pain with any weight
9. Walking	0 No pain; any distance	1 Increased pain after 1 mile	2 Increased pain after 1/2 mile	3 Increased pain after 1/4 mile	4 Increased pain with all walking
10. Standing	0 No pain after several hours	1 Increased pain after several hours	2 Increased pain after 1 hour	3 Increased pain after 1/2 hour	4 Increased pain with any standing

Patient Signature _____ **Date:** _____

Treating Doctor Signature _____ Date: _____

For office use only:
Total score _____ *Functional Rating Score* _____*%*

Institute of Evidence-Based Chiropractic