Francke Orange County Chiropractic Neurology

INTAKE FORM

Name: _____

Date of Birth: _____ **Occupation:** _____

Address: _____ **Referred by:** _____

Phone #: _____ **Email:** _____

Driver's License #: _____

Neighbor or Relative not living with you:

Name: _____ **Relation:** _____ **Phone #:** _____

❖ INSURANCE INFORMATION

Primary Insurance:

☐ **Medicare** ☐ **Chiropractic Coverage**

Insurance Co Name: _____ **Phone #:** _____

Member ID #: _____ **Policy #:** _____

Address: _____

Insured Name: _____ **Social Security #:** _____

Date of Birth: _____

Insured Relation to patient: _____

Insured Employer: _____ **Employer's Address:** _____

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❖ CHIEF COMPLAINT

What is your main complaint?

How long have you had this condition?

When was the first time you ever noticed you had this problem?

Is the problem getting: **Worse** ☐ **Better** ☐ **Same** ☐

Is it interfering with: **Work** ☐ **Sleep** ☐ **Exercise** ☐

What aggravates your symptoms?

What makes it better?

List other problems you have now:

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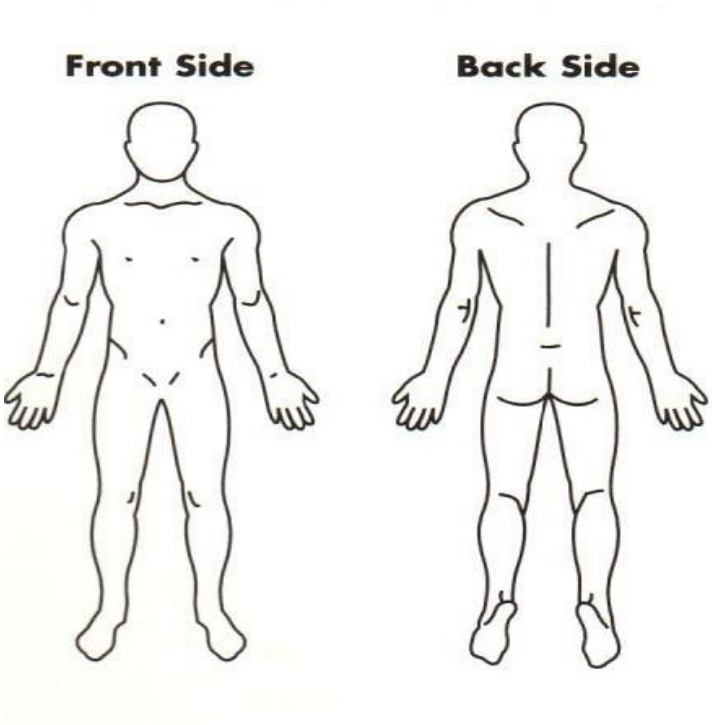
❖ PAIN SEVERITY:

Please mark the areas of injury or discomfort using the type of degree of pain



ACHING, SHARP, SWELLING,
DULL NUMBNESS
PINS & NEEDLES

DEGREE OF PAIN: 0 TO 10
0 = NO PAIN
10 = EXTREME PAIN

❖ MEDICAL HISTORY:

Do you have a personal physician? YES ☐ NO ☐

Physician Name: _____ **Phone #:** _____

List current health problems for which you are being treated:

_____

_____

_____

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What types of therapies have you tried for these problems to improve your health?

DIET CHANGE ☐ **VITAMINS** ☐ **CHIROPRACTIC** ☐ **ACUPUNCTURE** ☐ **HOMEOPATH** ☐

MEDITATION ☐ **OTHER** ☐

Daily vitamins/supplement intake:

Current medications (prescribed or over the counter):

Laboratory procedures performed (E.g.; Stool analysis, Blood & Urine chemistries, hair analysis …):

Hospitalizations, surgeries, injuries. Please list all procedures:

YEAR	Surgery, Illness, Injury	OUTCOME

HABITS (indicate amount):

Alcohol: _____ **Coffee:** _____

Cigarettes: _____ **Drugs not listed above:** _____

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Present exercise habits:

Please list main health problems in your family:

Name	Relation	Problem

Are you left or right handed:

Have you experienced any of the following?

- ☐ Abdominal Pain
- ☐ Abdominal Bleeding
- ☐ Acoustic Neuroma
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Autism Spectrum
- ☐ Autoimmune Disease
- ☐ Balance Difficulties
- ☐ Bell's Palsy
- ☐ Blood Transfusion
- ☐ Blurred Vision
- ☐ Bowel/Bladder Irregularities
- ☐ BPPV
- ☐ Broken Bones
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pressure
- ☐ Chicken Pox
- ☐ Chills
- ☐ Colitis
- ☐ Complex Regional Pain Syndrome
- ☐ Concussion
- ☐ Confusion
- ☐ Congenital Heart Failure
- ☐ Constipation

- ☐ **Convulsion**
- ☐ **CODD**
- ☐ **Depression**
- ☐ **Device/Pace Maker**
- ☐ **Diabetes**
- ☐ **Difficulty Breathing**
- ☐ **Drug Abuse**
- ☐ **Dyslexia**
- ☐ **Dystonia**
- ☐ **Ear Ache**
- ☐ **Emphysema**
- ☐ **Fainting Spells**
- ☐ **Fall**
- ☐ **Fatigue**
- ☐ **Fever Blisters**
- ☐ **Forgetfulness**
- ☐ **Frequent Urination**
- ☐ **Gait Abnormalities**
- ☐ **Glaucoma**
- ☐ **Gout**
- ☐ **Hay Fever**
- ☐ **Head Trauma**
- ☐ **Headaches**
- ☐ **Hearing Difficulties**
- ☐ **Heart Disease**
- ☐ **Hemophilia**
- ☐ **Hemorrhoids**
- ☐ **Hepatitis**
- ☐ **Herpes**
- ☐ **High Blood Pressure**
- ☐ **HIV Positive**
- ☐ **Increased Swelling**
- ☐ **Infected Wound**
- ☐ **Insomnia**
- ☐ **Joint Pain**
- ☐ **Kidney Problems**
- ☐ **Leaky Gut**
- ☐ **Leukemia**
- ☐ **Liver Disease**
- ☐ **Transplant**
- ☐ **Low Blood Pressure**
- ☐ **Lump in the Throat**
- ☐ **Lupus**
- ☐ **Meniere's**
- ☐ **Migraine**
- ☐ **Mitral Valve Prolapse**
- ☐ **Multiple Sclerosis**
- ☐ **Myopath**
- ☐ **Nausea/Vomiting**
- ☐ **Neuropathy**
- ☐ **Obesity**
- ☐ **Pacemaker**
- ☐ **Parkinson's**
- ☐ **Persistent Cough**
- ☐ **Pneumonia**
- ☐ **Poor Appetite**
- ☐ **Poor Circulation**
- ☐ **Processing Disorders**
- ☐ **Psychological Problems**
- ☐ **Rapid Heart Rate**
- ☐ **Rheumatic Fever**
- ☐ **Sciatica**
- ☐ **Scoliosis**
- ☐ **Seizures**
- ☐ **Shingles**
- ☐ **SIBO**
- ☐ **Sickle Cell Anemia**
- ☐ **Sinus Problems**
- ☐ **Skin Conditions**
- ☐ **Slow Heart Rate**
- ☐ **Stroke**
- ☐ **Suicidal Tendencies**
- ☐ **Swollen Joints**
- ☐ **Teeth Problems**
- ☐ **Tics**
- ☐ **Tingling in Hands/Feet**
- ☐ **Thyroid Problems**
- ☐ **Tonsillitis**
- ☐ **Transfusion**
- ☐ **Vascular Disease**

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- [ ] **Tremors**
- [ ] **Ulcers**
- [ ] **Urinary Dysfunction**
- [ ] **Venereal Disease**
- [ ] **Vestibular Problems**
- [ ] **Vision Problems**

Men:

- [ ] **Decrease Sex Drive**
- [ ] **Infertility**
- [ ] **Prostate**
- [ ] **Prostate Hyperplasia**

Date of last Prostate Exam: _____

Women :

- [ ] **Abdominal Cramps**
- [ ] **Breast Cancer**
- [ ] **Decreased Sex Drive**
- [ ] **Endometriosis**
- [ ] **Fibrosis**
- [ ] **Hysterectomy**
- [ ] **Infertility**
- [ ] **Irregular Periods**
- [ ] **Menopause:** **Date:** _____

Date of last menstrual cycle: _____

How many days are you bleeding? _____

Length of each cycle? _____

Any recent change in your bleeding? _____

Date of gynecological exam? _____

Printed Name: _____ **Patient Signature:** _____ **Date:** _____

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