RENO CHIROPRACTIC CLINIC, P.A.

3351 E 47th St So, Wichita KS, 67216
316-524-5700
CHIROPRACTIC INTAKE FORM

PATIENT INFORMATION DATE_____

Name _____ Social Security _____-____-_____ Cell Phone (_____) _____-_____

Address _____ City _____ St _____ Zip Code _____-_____

Age _____ DOB _____ Marital: M S W D Sex: M F # of Children _____ Cell Phone Carrier _____

E-mail _____ Your Employer _____

Name of Significant Other/Parent _____ Employer _____

Emergency Contact _____ Phone _____

Referred by _____
Is the condition due to injury or sickness arising out of employment ? _____
Is the condition due to injury or sickness arising out of auto accident ? _____
Is the condition due to injury or sickness arising out of other accident? _____
Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition: Yes _____ No _____ If yes, when and describe _____
_____

Date of last physical examination _____

What operations have you had? _____ When? _____

Serious illnesses _____ When? _____

Have you ever suffered from:

1. Dizziness: _____
2. Backaches: _____
3. Heart Troubles: _____
4. Diabetes: _____
5. Tuberculosis: _____
6. Arthritis: _____
7. Headaches: _____
8. Numbness: _____
9. Asthma: _____
10. Neuritis: _____
11. Digestive Disorders: _____
12. Nervousness: _____
13. Sinus Trouble: _____
14. Anemia: _____
15. Rheumatic Fever: _____

Purpose of this appointment _____

Your Primary Care Physician (PCP) _____

Other doctors seen for this condition _____
Have you been treated for any health condition by a physician in the last year? YES ( ) NO ( )
Describe _____

What medications or drugs are you taking? _____

HEALTH INSURANCE: YES ( ) NO ( )
Health Insurance Carrier _____

Insured's Name: _____
Insured's DOB: _____
Insured's Empl: _____
Insured's SSN: _____

I authorized direct payment of medical benefits to Reno Chiropractic Clinic, P.A. and release of medical information necessary to process my insurance claims.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

Reno Chiropractic Clinic, P.A.

Patient Name: _____ Date: _____

PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Main/Primary Complaint_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (cirele all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Secondary Complaint_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

3351 E. 47th Street South
Wichita, Kansas 67216
P: 316.524.5700
Fax 316.524.0707
Email: reno@chiroclinic.kscoxmail.com

Reno Chiropractic Clinic, P.A.

Patient Name: _____ **Date:** _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____
Date_____

3351 E. 47th Street South
Wichita, Kansas 67216
P: 316.524.5700
Fax 316.524.0707
Email: reno@chiroclinic.kscoxmail.com