

Welcome to Our Office
Intake Form

First Name _____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (____) _____ - _____ **Work Phone** (____) ____ - _____

Cell Phone (____) _____ - _____ **Date of Birth** ____/____/____

Email _____

Marital Status: Single Married Other **Sex:** Male Female

Employment Status: Employed Unemployed FT Student PT Student Other ____

Employer Data

Employer _____

Your Occupation _____

Spouse Data

First Name _____ **Last Name** _____

Home Phone (____) _____ - _____ **Spouse Date of Birth** ____/____/____

How did you hear about our office? _____

PAYMENT POLICY: **INSURANCE:** Y / N **Provider:** _____ **Provider ID#** _____

Thank you for choosing Dr McSweeney as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. If you would like to be provided a superbill for insurance reimbursement please ask and we would be happy to prepare that for you. Please read it, ask any questions you may have, and sign in the space provided below.

I have read and understood the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party **Date**

Medical Conditions: (Circle all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | Fibromyalgia | Asthma | Osteoporosis |

Surgeries: (Circle all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Breast Augmentation | Other _____ | | |

Allergies: (Circle all that apply to you)

- | | | | |
|---|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Mold | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Animal |
| <input type="checkbox"/> Chemical _____ | Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: (Circle all that apply to you)

- | | | | |
|----------------|---|--|-----------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Water: | <input type="checkbox"/> <64 oz/day | <input type="checkbox"/> >64 oz/day | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Sleep: | <input type="checkbox"/> <8 hours/night | <input type="checkbox"/> >=8 hours/night | Insomnia <input type="checkbox"/> |
| Other _____ | | | |

Family History: (Circle all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____ | | |

Occupational Activities: (Circle one that best describes your job description)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Other _____ | | | |

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	Respiratory			No	Allergic/Immunologic			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	No
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

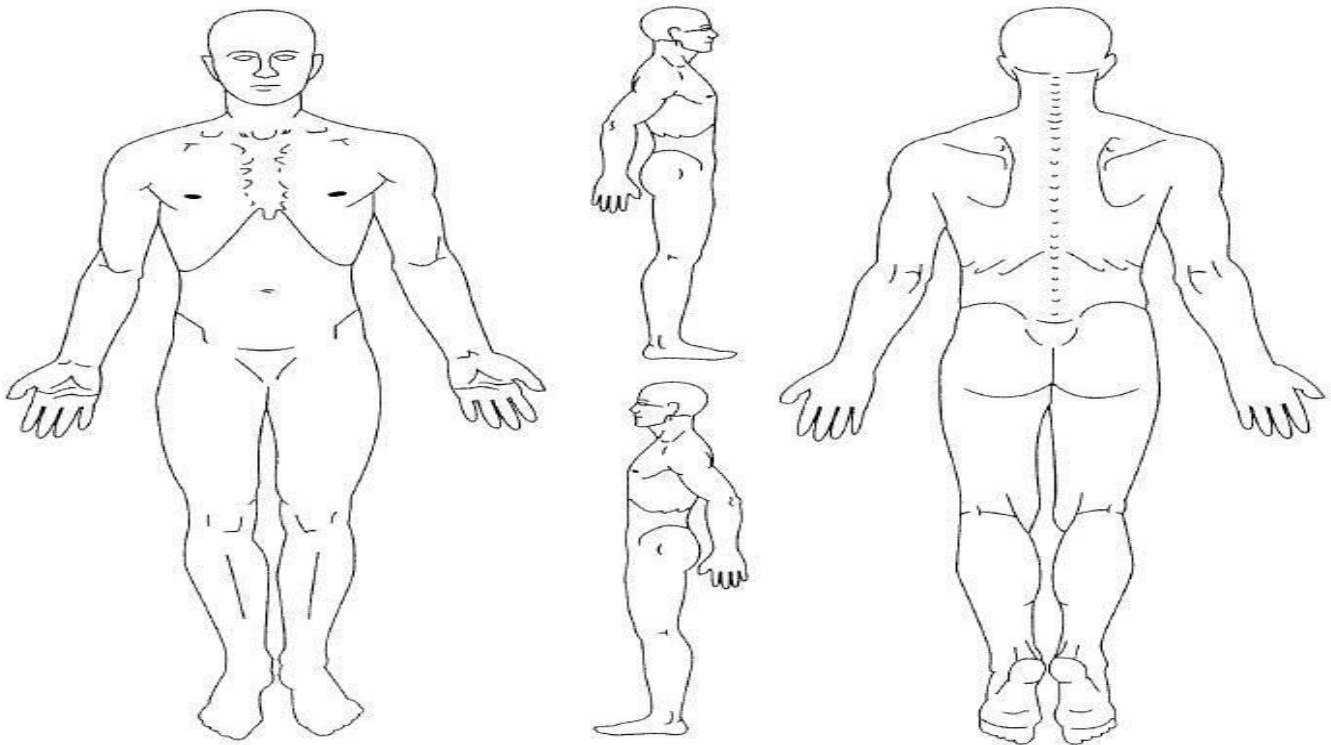
Please list all current medications/Supplements being taken

How are your symptoms changing? Getting better Not changing Getting worse

Are You Pregnant? (Check) Yes No

Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No If Yes, please list:

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin?

How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Other _____ |