Mountain View Chiropractic Center, PLLC - Louis S. Carr, D.C. – 207 North State Street Orem. UT 84057

# Patient Intake Form

Office Use only:
Vitals: BP ____/_____Heart Rate: _____
Height: _____ Weight: _____

**Date: _____/_____/_____**

## PERSONAL INFORMATION

**Patient Name:** _____ **Nickname?** _____
**Address:** _____ **City:** _____ **State:** ____ **Zip:** _____
**Driver's License #:** _____**State issued:** _____**Gender: Male/Female/Other**
**Marital Status:** S/M/D/W **Spouses Name:** _____**Ages of Children:** _____
**Date of Birth**: _____/_____/_____ **Phone:** (_____) _____-_____ **Cell:** (_____) _____-_____
**Email:** _____
**Who is your primary care physician?** _____

**Who referred you to our office?** _____**Relationship:** _____

## EMERGENCY CONTACT

**Name:** _____ **Phone:** (_____) _____-_____ **Relationship:** _____
**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

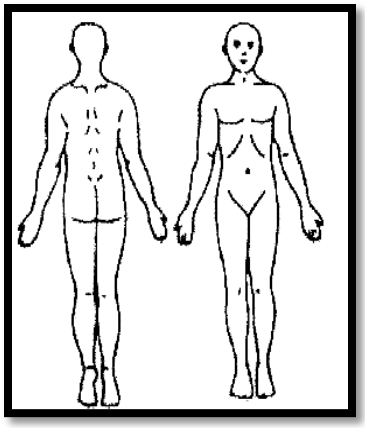
## EMPLOYMENT INFORMATION

**Current Employer:** _____ **City:** _____
**Job Title/Performance Requirements:** _____
**While YOU are responsible for your bill and our policy is for payment to be made at the time of service, will we be helping you to bill any of the following:___ Workers Comp ___ Auto Insurance ____ Medicare ____ Other (be specific):** _____

**PLEASE GIVE INSURANCE CARD (S) TO RECEPTIONIST**

## HISTORY OF PRESENT CONDITION

**Chief complaint (why are you here today**)? _____
_____
_____
**Date and time symptoms began?** _____
**Mechanism of Onset:**__ Auto __ Work __ Fall __ Lifting __ Overexertion __ Repetitive Motion
__ Cause Unknown__ Slept Wrong __ Slip or Fall __ Other (Explain)_____
**Describe in your own words how symptoms started?** _____
_____
_____
**How does this interfere with your life?** _____
_____



**Have you seen other doctors for this condition in the past or present?** € Yes € No
**If Yes, whom?** _____
**When did you see another doctor for this condition?** _____
**May we request records from this doctor?** € Yes € No
**Treatment or suggestions given:** _____
_____
**Were you satisfied with the results of your treatment?** € Yes € No
**Explain:** _____

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**Name:** _____ **Date:** _____

The following questions are in reference to the **HEAD AND NECK only** ∈ Head/Neck is my chief complaint

**Side:** ∈ Left ∈ Right **Describe Onset:** ∈Sudden ∈ Chronic ∈Gradual **Pain Caused By?**_____

**How have your symptoms changed?** ∈ Improving ∈ Getting Worse ∈ No Change **Since When?**_____

**What is the quality of the pain?** ∈Achy ∈Burning ∈Dull ∈Sharp ∈Stiff ∈Throbbing

**Description of Pain:** ∈Mild ∈ Moderate ∈Severe **Frequency of Pain:** ∈ Occasional ∈ Intermittent ∈ Frequent ∈ Constant

**Pain/Symptom Level in Neck:**

**0 1 2 3 4 5 6 7 8 9 10**

**Where does the pain radiate?**_____ **Numbness, Spasms, Weakness, etc?**_____

**When does it feel worse?** ∈ Morning ∈ As Day Progresses ∈ Afternoon ∈ Evening ∈ During the Night

**What makes it feel worse?** ∈Nothing ∈ Resting ∈ Sleeping ∈ Walking ∈ Working ∈ Movement ∈ Other_____

**When does it feel better?** ∈ Morning ∈ As Day Progresses ∈ Afternoon ∈ Evening ∈ During the Night

**What makes it feel better?** ∈ Hot ∈ Cold ∈ Massage ∈ Movement ∈ Medication ∈ Resting ∈ Sleeping ∈ Walking ∈ Chiropractic Care

**Headaches:**

**Location:** ∈ Front ∈ Back ∈ Side ∈ Behind Eye(s) **Type:** ∈Migraine ∈ Cluster ∈ Tension ∈ Drug Induced ∈ Other_____

_____

**What relieves the headaches?** ∈ Meds ∈ Time ∈ Other_____ ∈ Nothing **Frequency of Headaches:**_____

**Do you experience aura?** ∈ Yes ∈ No **Do you experience nausea with headache?** ∈ Yes ∈ No

The following questions are in reference to the **MID-BACK only** ∈ Mid-Back is my chief complaint

**Side:** ∈ Left ∈ Right **Describe Onset:** ∈Sudden ∈ Chronic ∈Gradual **Pain Caused By?**_____

**How have your symptoms changed?** ∈ Improving ∈ Getting Worse ∈ No Change **Since When?**_____

**What is the quality of the pain?** ∈Achy ∈Burning ∈Dull ∈Sharp ∈Stiff ∈Throbbing

**Description of Pain:** ∈Mild ∈ Moderate ∈Severe **Frequency of Pain:** ∈ Occasional ∈ Intermittent ∈ Frequent ∈ Constant

**Pain/Symptom Level in Mid-Back:**

**0 1 2 3 4 5 6 7 8 9 10**

**Where does the pain radiate?**_____ **Numbness, Spasms, Weakness, etc?**_____

**When does it feel worse?** ∈ Morning ∈ As Day Progresses ∈ Afternoon ∈ Evening ∈ During the Night

**What makes it feel worse?** ∈Nothing ∈ Resting ∈ Sleeping ∈ Walking ∈ Working ∈ Movement ∈ Other_____

**When does it feel better?** ∈ Morning ∈ As Day Progresses ∈ Afternoon ∈ Evening ∈ During the Night

**What makes it feel better?** ∈ Hot ∈ Cold ∈ Massage ∈ Movement ∈ Medication ∈ Resting ∈ Sleeping ∈ Walking ∈ Chiropractic Care

The following questions are in reference to the **LOW BACK only** ∈ Low Back is my chief complaint

**Side:** ∈ Left ∈ Right **Describe Onset:** ∈Sudden ∈ Chronic ∈Gradual **Pain Caused By?**_____

**How have your symptoms changed?** ∈ Improving ∈ Getting Worse ∈ No Change **Since When?**_____

**What is the quality of the pain?** ∈Achy ∈Burning ∈Dull ∈Sharp ∈Stiff ∈Throbbing

**Description of Pain:** ∈Mild ∈ Moderate ∈Severe **Frequency of Pain:** ∈ Occasional ∈ Intermittent ∈ Frequent ∈ Constant

**Pain/Symptom Level in Low Back:**

**0 1 2 3 4 5 6 7 8 9 10**

**Where does the pain radiate?**_____ **Numbness, Spasms, Weakness, etc?**_____

**When does it feel worse?** € Morning € As Day Progresses € Afternoon € Evening € During the Night

**What makes it feel worse?** € Nothing € Resting € Sleeping € Walking € Working € Movement € Other_____

**When does it feel better?** € Morning € As Day Progresses € Afternoon € Evening € During the Night

**What makes it feel better?** € Hot € Cold € Massage € Movement € Medication € Resting € Sleeping € Walking € Chiropractic Care

# Review of History

## Medication:

Are you currently taking any prescription medication? Yes ___ No ___ If yes, list below (be specific)

Medication Name: _____For: _____ Start date: _____ Frequency: _____

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(If more space is needed for medications, please advise the front desk receptionist)

## Childhood Illness

I…. ____ Deny Any Childhood Illness (es)

___ Scoliosis ___ Diabetes ___ Hepatitis ___ Asthma ___ Headaches ___ Eczema ___HIV

___ Ear Infection ___ Other (please describe)_____

## Allergies

**Allergies?** € Yes € No If Yes, describe cause and symptoms_____ _____

_____

## Adult Illness:

I… ___ Deny Any Adult Illness (es)

| | | | |
|---|---|---|---|
| __ Alzheimer | __ Cystic Kidney Disease | __ Fibromyalgia | __ Multiple Sclerosis |
| __ Anemia | __ Depression | __ Hepatitis | __ Parkinson's disease |
| __ Asthma | __ Diabetes (Insulin) | __ HIV | __ Lung Disease |
| __ Cancer | __ Diabetes (no insulin) | __ Hypertension | __ Pleurisy |
| __ Crohn's/Colitis | __ Ear Infections (frequent) | __ Liver Disease | __ Pneumonia |
| __ CRPS (RSD) | __ Emphysema | __ Lung Disease | __ Psychiatric Problems |
| __ CVA (stroke) | __ Eye Problems | __ Lupus | __ Scoliosis |
| __ Shingles | __ STD's (unspecified) | __ Suicide Attempt(s) | __ Thyroid Problems |
| __ Vertigo | __ Other Illness (please be specific):_____ | | |

## Surgeries:

I… ___ Deny Any Surgery (ies)

| | | | |
|---|---|---|---|
| __ Angioplasty | __ Cosmetic | __ Joint Reconstruction | __ Tonsillectomy |
| __ Appendectomy | __ D & C | __ Joint Replacement | __ Spinal Fusion |
| __ Caesarian Section | __ Dental Surgery | __ Laminectomy | __ Hysterectomy |
| __ Cardiac Catheterization | __ Gallbladder | __ Mastectomy | __ Repair Artery Bypass |
| __ Coronary | __ Hemorrhoidectomy | __ Pacemaker Insertion | __ Rotator Cuff |
| __ Carpal Tunnel | __ Hernia Repair | __ Other: _____ | |

## Injuries:

__ Back Injury __ Head Injury __ Mild/Moderate Soft Tissue Injury __ Fracture

__ Broken Bones __ Industrial Accident __ Severe Soft Tissue Injury __ Disability
__ Severe Fall __ Joint Injury __ Motor Vehicle Accident __ Severe Laceration
__Other: _____

**OB/GYN:**

__ I have never been pregnant __ I am currently pregnant

I have been pregnant a total of _____ times. Out of that number of pregnancies I had _____ number of complicated pregnancies and _____ number of uncomplicated pregnancies. During delivery I had _____ number of epidural injections _____ number of C-Sections and _____ number of vaginal deliveries.

**Hospitalization**

**Have you been hospitalized in the last 10 years?** € Yes € No If yes, state reason(s) and approximate date(s):

_____

**Family History**

€ I am unsure of my biological family history.

**Father:** € Alive - Significant diseases? _____ Cause of death: _____

**Mother:** € Alive - Significant diseases? _____ Cause of death: _____

**Paternal Grandfather:** € Alive - Significant diseases? _____ Cause of death: _____

**Paternal Grandmother:** € Alive - Significant diseases? _____Cause of death: _____

**Maternal Grandfather:** € Alive - Significant diseases? _____ Cause of death: _____

**Maternal Grandmother:** € Alive - Significant diseases? _____ Cause of death: _____

**Social History**

**Smoking Status**: € Never € Former Smoker € Live w/ Smoker € Current Smoker

**If you smoke; number** ____per ___day ___week ___month

**Alcohol:** € None € Casual € Moderate Drinker € Heavy Drinker

**Drug Use:** € None € Recreational € Addiction

**Exercise:** € Never € Daily € Weekly