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:** _____

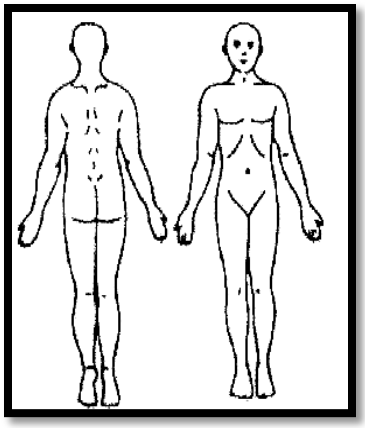
EMPLOYMENT INFORMATION

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

(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