

# Nordquist Family Chiropractic Intake Form

Patient # \_\_\_\_\_

Always Confidential

Date \_\_\_\_\_

## YOUR INFORMATION

Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Social Sec# \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Spouse \_\_\_\_\_ Phone \_\_\_\_\_

Referred by: \_\_\_\_\_

Google maps  Search engine  Friend  MD

Website  Advertisement  Other  \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

## CURRENT COMPLAINTS

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

STIFFNESS=S

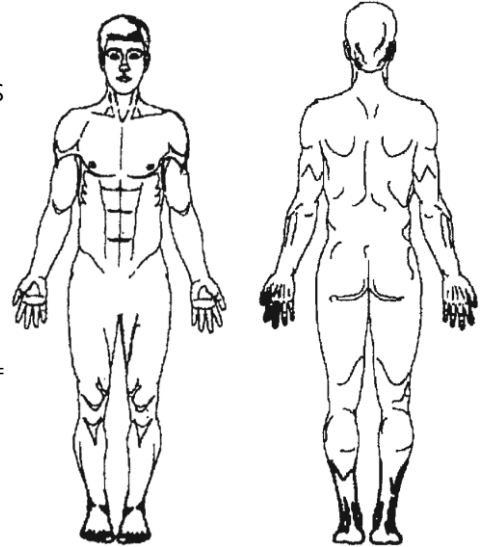
BURNING=B

TINGLING=T

PAIN=P

NUMBNESS=

ACHY=A



Pain Level: (none) 1 2 3 4 5 6 7 8 9 10 (worst)

Have you been treated for this before?  Yes  No  
When was your last Chiropractic Treatment?  
\_\_\_\_\_

## CONTACT INFORMATION

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Would you like text reminders for future appts?

Y  N  Carrier \_\_\_\_\_

Other Phone (\_\_\_\_\_) \_\_\_\_\_ Work  Home

Email \_\_\_\_\_

IN CASE OF EMERGENCY, PLEASE CONTACT

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Would you like your Chiropractic records sent to another health professional?

MD  PT  ND  Other \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_

## ACTIVITY INTOLERANCE

Are there any activities that you are having a hard time with because of your symptoms?

Anything you're not doing now that you would if you felt better? \_\_\_\_\_

## FAMILY HISTORY

Please list any history of family illness  
\_\_\_\_\_  
\_\_\_\_\_

## INSURANCE INFORMATION

Injury type? Work  Auto Injury  Other  None

Insurance Coverage \_\_\_\_\_

Secondary Ins \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_ DOB \_\_\_\_\_

## Women Only

Is there any chance you are pregnant? Y  N

If NO; I understand that x-ray can be harmful to a fetus.

However, I believe that I am not pregnant and my health concerns warrant the risk for any necessary x-rays.

Signature \_\_\_\_\_