RENO CHIROPRACTIC CLINIC, P.A.

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

PATIENT INFORMATION DATE________________________

Name ____________________________________ Social Security ______ - ____ - ________ Age _____ DOB ______________

Address __________________________________ City ________________________ St _____ Zip Code ____________-__________

Phone (______) ______-_____________ Cell Phone Carrier for Text Reminders ________________________ Marital: M S W D Sex: M F

Your Employer ______________________________________ Referred by ____

Name of Significant Other/Parent ______________________________________ Employer ________________________________

Emergency Contact ______________________________________ Phone ____

Is the condition due to injury or sickness arising out of employment? ☐ Yes ☐ No Auto accident? ☐ Yes ☐ No Other Accident? ☐ Yes ☐ No

Date symptoms appeared or accident happened ______________________ If other, please describe? ________________________________

Your Primary Care Physician (PCP) ____

Major surgeries or Operations? ____

What medications or drugs are you taking?____

Review Of Systems

Do you have, or have had, any of the following?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthrities/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
									Yellow Jaundice	☐ Yes	☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes ____

HEALTH INSURANCE: YES ( ) NO ( ) Health Insurance Carrier ____________________________________
Insured's Name: ______________________ Insured's DOB: ______________________
Insured's Empl: ______________________ Insured's SSN:______________________

I authorize 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 ___________________

04/2019

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PATIENT HISTORY FORM

We must assess your condition to understand how your reason for seeking care affects your ability to manage everyday activities.

Patient Reason for Seeking Care ________________________________

- On a scale of 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:

  10 20 30 40 50 60 70 80 90 100 (Circle one)

- When did the symptom begin? ____________________ How? ______________________ Gradually or Suddenly?
- What makes the symptom worse? (Mark all that apply):

  ☐ Bending Forward ☐ Bending Backward ☐ Tilting to left ☐ Tilting to right ☐ Turning to left ☐ Turning to right
  ☐ Twisting left ☐ Twisting right ☐ Sitting ☐ Standing ☐ Sitting to Standing ☐ Lifting ☐ Driving ☐ Walking
  ☐ Running ☐ Nothing ☐ Any Movement ☐ Other (please describe): ____________________________________

- What makes the symptom better? (Mark all that apply):

  ☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Pain Medication ☐ Muscle Relaxers ☐ Nothing
  ☐ Other (please describe): ____

- Describe the quality of the symptom (Mark 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 Where? _________________________
- Is the symptom worse at certain times of the day or night? (Mark one)

  ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

Functional Rating

Please circle the number which most closely describes your condition right now

1. Pain Intensity

0	1	2	3	4
None	Mild	Moderate	Severe	Worst

2. Sleeping

0	1	2	3	4
Perfect	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Needs to go slowly	Moderate Pain; Needs some Assistance	Severe Pain; Needs 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus extra	Can do usual work but no extra	Can do 50% of work	Can do 25% of work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any

7. Frequency of Pain throughout the Day

0	1	2	3	4
0%	25%	50%	75%	100%

8. Lifting

0	1	2	3	4
No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain after any standing

Patient or Guardian Signature ______________________________ **Date** _______________

Print Name _____________________________