

Flagler Chiropractic, PA
1240 S. Ocean Shore Blvd.
Flagler Beach, FL 32136

New Patient Intake Form

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

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

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

Cell Phone (____) _____ - _____ **Email** _____

Date of Birth ____/____/____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Employer Data _____

Employer _____

Your Occupation _____

Spouse Data _____

First Name _____ **Middle Initial** ____ **Last Name** _____

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

Spouse Date of Birth ____/____/____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| ☐ Arthritis | ☐ Cancer | ☐ Diabetes | ☐ Heart Disease |
| ☐ Hypertension | ☐ Psychiatric Illness | ☐ Skin Disorder | ☐ Stroke |
| ☐ Other _____ | ☐ Fibromyalgia | ☐ Asthma | ☐ Osteoporosis |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| ☐ Appendectomy | ☐ Cardiovascular procedure | ☐ Cervical spine | ☐ Hysterectomy |
| ☐ Joint Replacement | ☐ Prostate | ☐ Lumbar spine | ☐ Gall Bladder |
| ☐ Brain | ☐ Shoulder | ☐ Thoracic spine | ☐ Knee |
| ☐ Carpal Tunnel | ☐ Gastro-intestinal | ☐ Uro-genital | ☐ Hernia |
| ☐ Breast Augmentation | ☐ Other _____ | | |

Allergies: (Check all that apply to you)

- | | | | |
|---|-----------------------------------|--|--------------------------------------|
| ☐ Mold | ☐ Seasonal | ☐ Milk or Lactose | ☐ Animal |
| ☐ Chemical _____ | ☐ Sulfites | ☐ Wheat/Glutens | ☐ Other _____ |

Social History: (Check all that apply to you)

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

Family History: (Check all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | ☐ Parent | ☐ Sibling |
| Cancer: | ☐ Parent | ☐ Sibling |
| Diabetes: | ☐ Parent | ☐ Sibling |
| Heart Disease | ☐ Parent | ☐ Sibling |
| Hypertension | ☐ Parent | ☐ Sibling |
| Stroke | ☐ Parent | ☐ Sibling |
| Thyroid | ☐ Parent | ☐ Sibling |
| Other _____ | | |

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

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

Patient Name _____ Date _____

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	
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 being taken _____

How are your symptoms changing? Getting better Not changing ☐ Getting worse
Are You Pregnant? (Circle) Yes No

Patient Name _____ **Date** _____

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

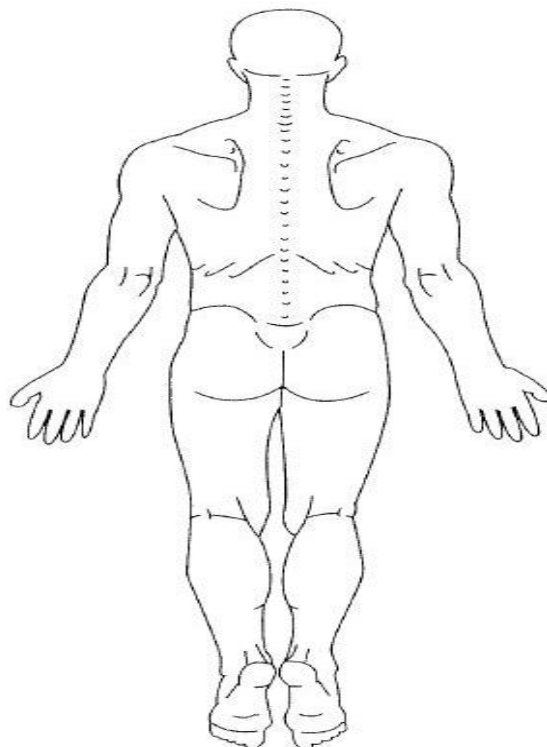
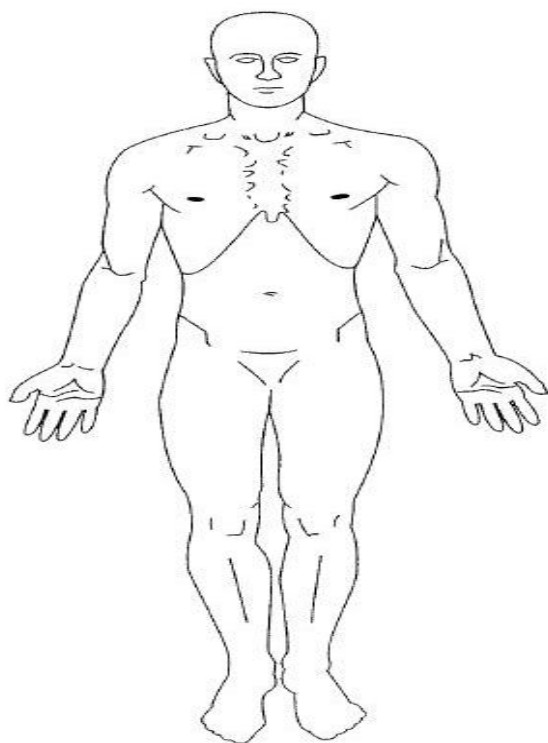
N=Numbness

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?

☐ Constantly
(76-100% of the day)

☐ Frequently
(51-75% of the day)

☐ Intermittently
(26-50% of the day)

☐ Occasionally
(0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp
☐ Burning

☐ Ache
☐ Tingling

☐ Numb
☐ Throbbing

☐ Shooting
☐ Other _____

Patient Name _____ Date _____

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