New Patient Intake Form

Cornerstone Chiropractic Clinic-13470 N 83rd Ave, Ste 302-Peoria, AZ 85381-623-249-7141 Jessica J. Haug DC

Name: _____ SSN:_____ Date:_____ File #_____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____ -_____ Cell Phone: (____) _____ -_____
Email Address:_____ May we contact you via email? ___ Yes ___ No
Age : _____ Date of Birth: ____/_____/_____ Marital Status: M S W D
Occupation: _____ Employer: _____
Work Phone: (____) _____ -_____
Spouse's Name: _____ Phone: (____) _____ -_____
Name of Nearest Relative: _____ Phone: (____) _____ -_____
Names and Ages of any Children:
_____
Family Medical Doctor:
_____
How were you referred to our office?
_____

HISTORY OF PRESENT ILLNESS

Purpose of this appointment (wellness or specific concern)_____
Explain:_____
_____
_____
When did you first notice the problem?
_____
How did it originally occur?
_____
How has it progressed recently? (circle) Same/ Improving/ Getting Worse
How frequent is the condition? (circle) Constant/ Frequently/ Intermittent/ Occasionally
Describe the pain: (circle all that apply) Sharp/Dull/Numbness/Tingling/Aching/Burning/Stabbing/Throbbing
Other: _____
Does anything relieve the problem? If so, please list. _____ No _____ Yes:
_____
What does this problem prevent you from doing or enjoying?
_____

PAST MEDICAL HISTORY

Please check any of the following conditions that you have been diagnosed with or experienced.

____ Broken or Fractured Bones	____ Osteoarthritis	____ Eating Disorders
____ Circulatory Problems	____ Epilepsy	____ Alcoholism
____ Rheumatoid Arthritis	____ Pace Maker	____ Drug Addiction
____ Seizures/Convulsions	____ Strokes	____ HIV Positive
____ Any Congenital Diseases	____ Cancer	____ Gall Bladder Problems
____ Excessive Bleeding	____ Ruptures	____ Depression
____ High/Low Blood Pressure	____ Coughing Blood	____ Ulcers
____ Ringing in the Ears	____ Dizziness	____ Glaucoma
____ Diabetes	____ Metal Screws	____ Osteoporosis

Please list any major illnesses, injuries, falls, auto accidents, or surgeries (including dates). Women include information regarding childbirth.

_____
_____
_____
_____
_____

Have you been treated, for any health condition, by a physician within the last year? ____ No ____ Yes
If yes, describe:

_____
_____

Are you taking any medications or drugs (including prescription and over the counter) ____ No ____ Yes
If Yes, Please list:

_____
_____
_____

Are you taking any supplements?____No _____Yes
If Yes, Please List:

_____
_____
_____

Women: Is there any chance you may be pregnant? ____ Yes ____ No ____ Not Sure
Please list any additional health problems you have, no matter how insignificant they may be.

_____
_____
_____

SOCIAL HISTORY

Please check the following that apply to your lifestyle. (Please describe frequency and type)
____ Alcohol _____
____ Tobacco Products _____
____ Caffeine _____
____ Exercise _____
____ Hobbies _____
What percentage of the day are you:____% Lifting ____% Sitting ____%Bending ____%Working at a Computer?

FAMILY HISTORY

Please check any conditions that run in your family and indicate whether the family member is your **G**randparent, **F**ather, **M**other, **S**ister, or **B**rother.

____ Diabetes	____ Cancer	____ Mental Illness	____ Arthritis
____ Stroke	____ Asthma	____ Kidney Disease	____ Liver Disease
____ Heart Disease	____ Lung Disease	____ Other:_____	

ANY other pertinent information that the doctor should be aware of:_____No_____Yes
If yes, please describe:

_____
_____

_____ Date: _____
Patient (or Guardian) Signature