0Whom may we thank for referring you to this office → _____?

Van Zeilen Family Chiropractic PLLC
New Patient Intake Form

Today's Date: _____ Pat #:_____

PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ SS#: _____-_____-_____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone: _____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Insurance member ID: _____

Subscriber name: _____ Birth Date: ____-____-_____ Relationship to patient: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse's Name _____ Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Main problem: _____

Second: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the main problem begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

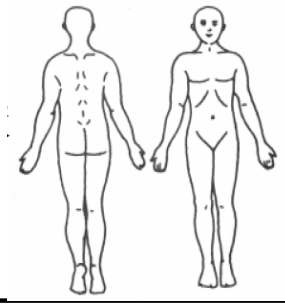
How did the main complaint happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 2- Activities of Life

FAMILY HISTORY:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	__	__	__	__	_____
Mother's Side	__	__	__	__	_____

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Van Zeilen Family Chiropractic PLLC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [CLINIC NAME] for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ HR#: _____ ___/___/___ **JDD,DC 5/2011**

Patient ID# _____

Van Zeilen Family Chiropractic PLLC

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
_ Asthma/difficulty breathing _ COPD _ Emphysema _ Other _____ _ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
_ Heart surgeries _ Congestive heart failure _ Murmurs or valvular disease _ Heart attacks/MIs _ Heart disease/problems _ Hypertension _ Pacemaker _ Angina/chest pain _ Irregular heartbeat _ Other _____ _ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
_ Visual changes/loss of vision _ One-sided weakness of face or body _ History of seizures _ One-sided decreased feeling in the face or body _ Headaches _ Memory loss _ Tremors _ Vertigo _ Loss of sense of smell _ Strokes/TIAs _ Other _____ _ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
_ Thyroid disease _ Hormone replacement therapy _ Injectable steroid replacements _ Diabetes _ Other _____ _ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
_ Renal calculi/stones _ Hematuria (blood in the urine) _ Incontinence (can't control) _ Bladder Infections _ Difficulty urinating _ Kidney disease _ Dialysis _ Other _____ _ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
_ Nausea _ Difficulty swallowing _ Ulcerative disease _ Frequent abdominal pain _ Hiatal hernia _ Constipation _ Pancreatic disease _ Irritable bowel/colitis _ Hepatitis or liver disease _ Bloody or black tarry stools _ Vomiting blood _ Bowel incontinence _ Gastroesophageal reflux/heartburn _ Other _____ _ None of the above

Have you had any of the following **hematological (blood-related)** issues?
_ Anemia _ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) _ HIV positive _ Abnormal bleeding/bruising _ Sickle-cell anemia _ Enlarged lymph nodes _ Hemophilia _ Hypercoagulation or deep venous thrombosis/history of blood clots _ Anticoagulant therapy _ Regular aspirin use _ Other _____ _ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
_ Significant burns _ Significant rashes _ Skin grafts _ Psoriatic disorders _ Other _____ _ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
_ Rheumatoid arthritis _ Gout _ Osteoarthritis _ Broken bones _ Spinal fracture _ Spinal surgery _ Joint surgery _ Arthritis (unknown type) _ Scoliosis _ Metal implants _ Other _____ _ None of the above

Have you had any of the following **psychological** issues?
_ Psychiatric diagnosis _ Depression _ Suicidal ideations _ Bipolar disorder _ Homicidal ideations _ Schizophrenia _ Psychiatric hospitalizations _ Other _____ _ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dr. Kris Van Zeilen, Van Zeilen Family Chiropractic PLLC.

Patient or Guardian Signature _____

Patient Name (Print): _____ Date: _____

Patient ID# _____