RockRiver
CHIROPRACTIC & ACUPUNCTURE
2201 52nd Avenue
Moline, IL 61265
(309)-797-0707

**New Patient Intake Form**

**Patient Information**

Last Name_____ MI____ First Name_____ Date_____

Address_____City/State/Zip_____

Date of Birth_____ SSN_____ Marital Status **M S W D** Sex **M F**

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Occupation_____ Employer_____

Employer's Address_____

Spouse_____ Occupation_____ Employer_____

Spouse's Birth Date_____ Children/Names/Ages_____

How were you referred to our office?_____

Emergency Contact_____ Contact Phone_____

Have you received chiropractor care in the past? **Yes / No**

If yes describe the reason for previous care_____

Family Medical Doctor_____

**Patient Condition**

Reason for visit_____

Is this condition due to an accident? **Yes / No** Work___ Auto___ Home___ Other_____

Date of injury_____ Date symptoms occurred_____

Have you ever had the same or similar condition? **Yes / No** If yes, please describe_____

_____

How often do you have this problem?_____ Has it changed? ___Better ___Worse ___Same

What makes it better?_____ What makes it worse?_____

Is this condition affecting your sleep? **Yes / No** If yes, please describe_____

_____

Is this condition affecting your ability to perform your job or daily activities? **Yes / No** If yes, please describe_____

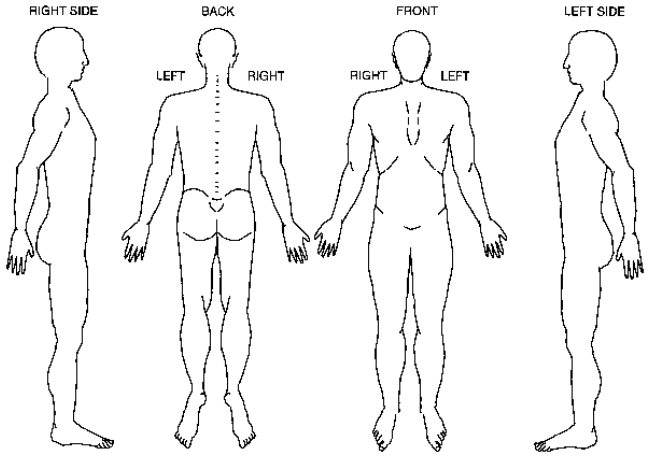
What treatments have your received or tried for this condition?_____

Are there any other symptoms that may be related to these concerns, which you have not listed? ___Yes ___No

If yes, please describe:

_____

Please mark any areas of concern on the diagrams below. N – numbness P- pins & needles B- burning A- aching S-stabbing. Indicate any other problems as best you can.




**Medications/Allergies/Vitamins**

Are you taking any medications? If so, please provide the name and the condition it is for_____

_____

Do you have any allergies? _____

Are you taking any vitamins/supplements/herbs? Is so, please provide the name and reason_____

_____

**Personal Health History**

Do you wear contacts/glasses? **Yes / No**

**Women Only** (Check all that apply)

| | | |
|---|---|---|
| ___Difficult Periods | ___Hot Flashes | ___Irregular Cycles |
| ___Breast Pain | ___Lump in Breast | ___Difficulty Becoming Pregnant |
| ___Pregnancy Complications | ___Pain With Intercourse | ___Pelvic Pain |

Date last period started_____
Date last gynecological exam_____
Are you pregnant or chance that you could be? **Yes / No**

**Men Only** (Check all that apply)

| | | |
|---|---|---|
| ___Testicular Pain | ___Prostrate Problems | ___Difficulty with Erection |
| ___Low Sperm Count | ___Pain with Intercourse | ___Pelvic Pain |

Have you ever been diagnosed as having or suffered from? (Check all that apply)

___Headaches
___Neck Pain
___Stiff Neck
___Sleeping Problems
___Back Pain
___Nervousness
___Tension
___Irritability
___Chest Pains/Tightness
___Dizziness
___Feet/Hands Cold
___Weakness in Extremities
___Shoulder/Neck/Arm Pain
___Pinched Nerve
___Numbness in Fingers
___Numbness in Toes
___High Blood Pressure
___Poor Circulation
___Heart Disease
___Nose bleeds
___Fainting
___Disc Problems
___Stroke
___Cancer
___Gout
___Loss of Hearing
___Loss of Balance
___Loss of Memory
___Loss of Smell
___Loss of Taste
___Unusual Bowel Patterns
___Difficulty Urinating
___Thyroid Disorders
___Joint Pain/Swelling
___Arthritis
___TMJ Problems
___Muscle Spasms
___Frequent Colds
___Fever/Chills/Sweats
___Nausea/Vomiting
___Sinus Problems
___Difficulty Swallowing
___Ulcers
___Scoliosis
___Osteoporosis
___Skin Conditions
___Immune Disorders
___Diabetes
___Indigestion Problems
___Hepatitis
___Blood Clots
___Kidney Disease
___Kidney Stones
___Fatigue
___Ears Ring
___Weight Loss/Gain
___Parkinson's Disease
___Multiple Sclerosis
___Glaucoma
___Lights Bothers Eyes
___Double Vision
___Breathing Problems
___Asthma
___Depression
___Anxiety

Have you had or experienced the following: (if so check, describe, and date)

___Falls_____

___Head Injuries_____

___Broken Bones/Dislocations_____

___Hospitalization_____

___Surgery_____

___Sprains/Strains_____

___Loss of Consciousness_____

___Mental/Emotional Disorder_____

**Family History**

Family Members- Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, stroke, hypertension, lung disease, brain disorder, seizures, tremors, etc.)_____

_____

_____

_____

**Social History**

Do you exercise? **Yes No** If yes, what is the frequency and type?_____

How is your diet? ___Good ___Fair ___Poor

Are you satisfied with your weight? **Yes / No** Has your weight changed in the past year? **Yes / No**

Work activity? ___Sitting ___Standing ___Light Labor ___Moderate Labor ___Heavy Labor

How many hours of sleep do you get?_____

Habits: (Check any that apply)

| | |
|---|---|
| ___Tobacco | Type & Amount_____ |
| ___Alcohol | Amount_____ |
| ___Drugs | Amount_____ |
| ___Coffee/Caffeine | Cups/Day_____ |
| ___High Stress Level | Reason_____ |

Is there anything else that you would like to discuss that is not mentioned in this form?_____

_____

_____

I ATTEST THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

I understand and agree that the health accident/insurance policies are an arrangement between the insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be due immediately and payable.

Signature of Patient/Legal Guardian:

_____ Date:_____

Printed Name of Patient/Legal Guardian _____