Insert Logo Here

Goodyear Chiropractic

11 W Van Buren St., Ste. 28
Avondale, AZ 85323
(623)932-4060(P)
(623)932-4417(F)

Patient Intake Form

Date _____

First Name _____
Last Name _____
DOB _____
Sex ◯ Male ◯ Female
SSN _____
Address _____
City _____
State _____
Zip Code _____

Phone 1 _____
◯ Mobile ◯ Home ◯ Work
Phone 2 _____
◯ Mobile ◯ Home ◯ Work
Email _____
Employer _____
Employer Phone _____
Occupation _____

Marital Status
◯ Single ◯ Married ◯ Other

Working Status
◯ Employed
◯ Full-Time Student
◯ Part-Time Student

Reason For Visit ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury
◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other _____

Referred By ◯ Provider ◯ Friend ◯ Family ◯ Other _____
Referred By Name _____

How Heard of Us ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website
◯ Advertisement ◯ Other _____

Demographics

Race ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian or Other Specific Islander ◯ Other _____

Ethnicity ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Other _____

Dominance ◯ Right ◯ Left ◯ Ambidextrous

Insurance Information

Primary Insurance

Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____
Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Secondary Insurance

Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____
Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Emergency Contact Information

First Name _____ Relationship _____

Last Name _____ Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements

Allergies

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Chicken Pox	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Allergy Shots	☐ Chronic Fatigue	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Anemia	☐ Depression	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Arthritis	☐ Diabetes	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Asthma	☐ Emphysema	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Bleeding Disorders	☐ Epilepsy	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Breast Lump	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Bronchitis	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Chemical Dependency	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries

Traumas

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Reason for visit: _____

Is there anything that makes your condition better? _____

Is there a time of day worse than others? _____ Where specifically is the problem located? _____

Frequency: _____ times per ◯ Day ◯ Week ◯ Month ◯ Year

Duration: Lasting _____ ◯ Minutes ◯ Hours

Onset: Have had symptoms over the past _____ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Moderate ◯ Slight ◯ Severe

Is your condition: ◯ Same ◯ Better ◯ Worse

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

How does your pain interfere with your daily activities (work, sleep, sex, etc.) ? _____

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic

☐ Low (Time of Day) _____ ☐ High (Time of Day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ◯ None ◯ Moderate ◯ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? _____

Daily Habits

Do you smoke? ◯ Unknown if ever smoked ◯ Current status unknown ◯ Current every day smoker

◯ Current some day smoker ◯ Former smoker ◯ Never smoked

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ Yes ◯ No Please describe _____

Review of Systems

Musculoskeletal: Please check all that apply

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm
☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations ☐ Persistent Coughing
☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)
☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps
☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing
☐ Other _____

Eyes: Please check all that apply

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma
☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

Ears: Please check all that apply

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing
☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds
☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

Throat/Mouth: Please check all that apply

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness
☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling
☐ Thrush ☐ Tooth pain ☐ Other _____

Urinary: Please check all that apply

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary track infections
☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)
☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

Gastrointestinal: Please check all that apply

☐ Change in appetite ☐ Change in bowl habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea
☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Endocrine: Please check all that apply

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst
☐ Frequent urination ☐ Heat intolerence ☐ Sweating

Vascular/Hematologic: Please check all that apply

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia
☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness
☐ Worry/anxiety ☐ Other _____

Psychiatric: Please check all that apply

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

Female

Are you pregnant? ◯ Yes ◯ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____ Form of birth control _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

Male: Please check all that apply

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____
And assign directly to the above named Chiropractic clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named Chiropractic clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date _____

Print Name of Patient, Parent, Guardian or Personal Representative