Rozenhart Family Chiropractic - New Patient Intake

Name:_____ Date:_____

Address:_____ City:_____ State:_____Zip:_____

Cell ( )_____ Home ( )_____ Work ( ) _____

** We use text and email for appointment reminders.

Email:_____ Male _____ Female_____

Social Security #_____ Birthdate:_____ Age: _____

Single:_____ Married:_____ Spouse's Name:_____

Occupation:_____ Employer/address:_____

Have you seen a Chiropractor before? Yes No

If yes,when?_____

Whom may we thank for referring you to our office?_____

YOUR HEALTH SUMMARY

Please check all symptoms you have ever had, even if they do not seem to relate to your current problem.

__ Headaches	__Pins & needles in legs	__Fainting	__Neck Pain	__Pins & needles in arms
__Loss of smell	__Numbness in fingers	__Loss of balance	__Dizziness	__Buzzing in ears
__Fatigue	__Nervousness	__Ringing in ears	__Back Pain	__Loss of taste
__Stomach upset	__Numbness in toes	__Depression	__Irritability	__Tension
__Stiff neck	__Sleeping problems	__Cold hands	__Cold feet	__Lights bother eyes
__Diarrhea	__Constipation	__ Problems urinating	__Fever	__Menstrual irregularity
__Hot flashes	__Cold Sweats	__Menstrual pain	__Heartburn	__Ulcers
__Mood swings				

List any medications you are taking_____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

Guardian Signature_____ Date_____

Functional Rating Index

For use with Neck and/or Back problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the **ONE** choice which most closely describes your condition right now.

1. **Pain Intensity**

No pain	Mild pain	Moderate pain	Severe pain	Worst Possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Traveling

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst Possible pain

7. Frequency of Pain

No pain	Occasional pain 25% of day	Intermittent pain 50% of day	Frequent pain 75% of day	Constant pain 100% of day

8. Lifting

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with any walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour standing	Increased pain after ½ hour standing	Increased pain with any standing

Name:_____ Date_____
Printed

_____
Signature