Whitefish CHIROPRACTIC

Dr. Ryan M. Wigness

NEW PATIENT INTAKE FORM

Date_____

Name_____ Male/Female

Mailing address _____

City _____ State_____ Zip code _____

Home phone ( )_____ Cell phone ( ) _____

Work phone ( ) _____

Age _____ Birth Date_____ Social Security # _____

Marital Status M S W D No. of children _____ Email _____

Occupation _____ Employer_____

Spouse Name _____ Spouse Employer _____

Name of Emergency Contact _____ Phone # _____

How do you prefer to be verbally addressed? _____

Whom may we thank for referring you?_____

Family Dr./Primary Care Physician _____

_____

1) Present Complaint _____

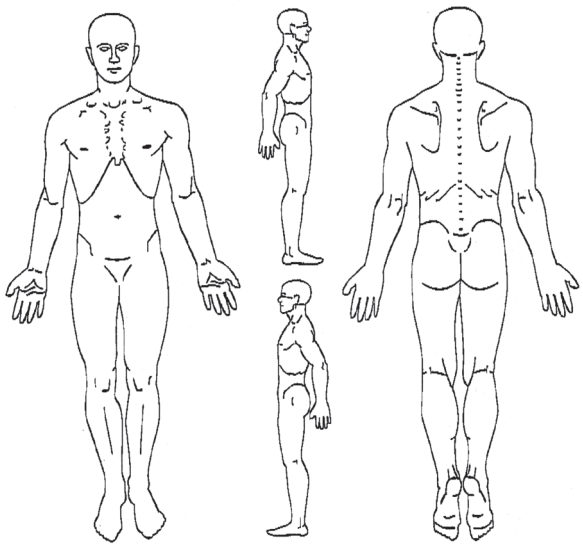
_____

_____

2) When did your problem begin? Specific date if possible _____

3) How did your problem begin? _____

MARK ON THE PICTURES WHERE YOU HAVE PAIN
OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN,
NUMBNESS OR TINGLING, ETC.



Using the line scale, rate the pain you experience NOW:

No Pain 1 _____ 10 Severe Pain

Is there any dizziness associated with symptoms? YES / NO

4) In the past have you had anything similar to this? YES / NO Please explain _____

_____

5) For your present complaint have you seen any other doctor? YES / NO If yes, who _____
What treatment? _____

6) How intense is the pain? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe/Excruciating

7) Please describe the character of your current pain (check one or more that apply)
☐ Sharp ☐ Burning ☐ Shooting ☐ Aches ☐ Soreness ☐ Numbness ☐ Dull ☐ Stiff ☐ Tingling
☐ Other _____

8) How often are the complaints present?
☐ Constant 100% of the time ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25%
☐ Other _____

9) Is the pain ☐ Increasing ☐ Decreasing ☐ Not Changing

10) Pain is aggravated by ☐ Walking ☐ Sitting ☐ Standing ☐ Riding in car ☐ Lifting ☐ Bending
☐ Stretching ☐ Twisting ☐ Other _____

11) Pain is reduced by ☐ Medicine ☐ Exercise ☐ Rest ☐ Adjustments ☐ Therapy
☐ Other _____

12) What would you like to do, but can't, because of the pain? _____

13) Are your complaints affecting your ability to work or be active? ☐ No effect ☐ Some physical restrictions
☐ Unable to perform regular duties.

14) Any fever or chills? YES / NO

15) Are your complaints affecting your ability to sleep? YES / NO

16) Any changes in bowel or bladder (bathroom) function? YES / NO

17) Have you missed any days of work or school? YES / NO Dates missed _____

18) Please list any allergies (drug or other) _____

19) Have you broken any bones YES / NO Please explain _____

20) Have you been in the hospital or had surgery for any reason? YES / NO Please explain _____

_____

21) Have you ever been in a major car accident? YES / NO Please explain _____

_____

22) What prescription medications or drugs are you taking? _____
☐ Anti-inflammatory ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure ☐ Insulin ☐ Birth Control
☐ Tranquilizers ☐ Diet Pills ☐ Nerve Pills ☐ Other _____

23) What non-prescription meds are you taking? ☐ Tylenol ☐ Ibuprofen ☐ Aspirin
☐ Other _____

24) Do you smoke? YES / NO How much? _____

25) Do you drink? YES / NO How much? _____

26) What is your exercise routine? _____

27) Other health concerns? _____

_____

28) What do you hope to achieve from this visit? Check all that apply.
☐ Pain relief ☐ Explanation of your condition ☐ Education/exercises to prevent recurrence

29) Are you seeking ☐ Lasting corrective care ☐ Temporary relief

30) Do you have insurance? YES / NO Name of Insurance Co. _____