Intake Form 1

Phipps Soft Tissue and Spine Chiropractic
390 S Youngs Rd, Williamsville, NY 14221
Phone: 716-629-3100 | Fax: 716-629-3199

Date _____

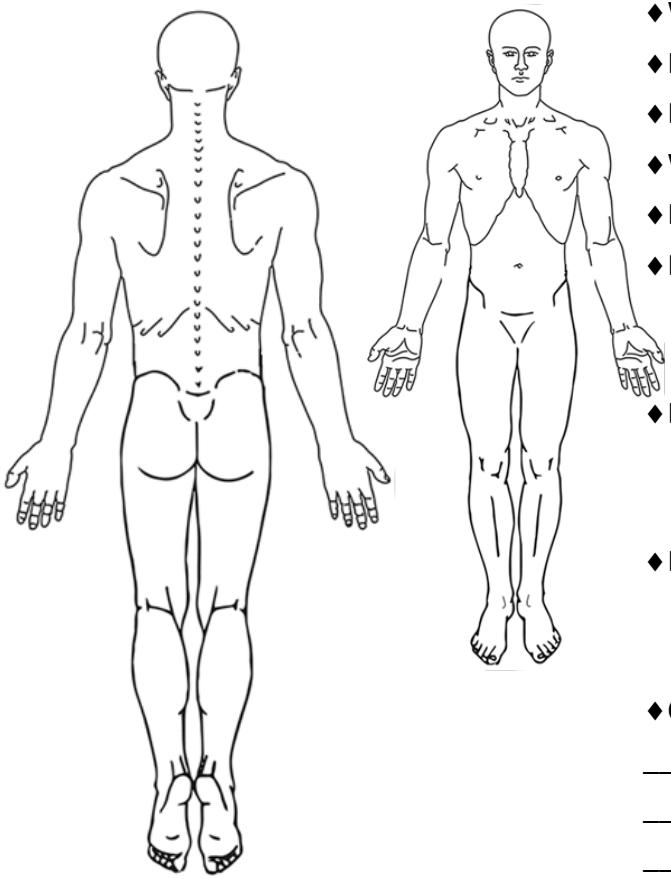
**Patient Information**

Name:_____ E-mail:_____
How do you prefer to be verbally addressed? _____
Address_____
City_____ State_____ Zip_____
Cell Phone (_____) _____ □home □ work (_____) _____ Date of Birth _____
Sex □ M □ F Height:_____ Weight:_____ Marital Status □ S □ M □ D □ W
Primary Care Physician: _____ Address _____
Occupation: _____ How did you find out about us? _____

Name of Emergency Contact_____ Phone # (____) _____

**Primary Complaint (Fill this section out pertaining to the region that you would like diagnosed and treated first)**

♦Mark the location of primary pain below:



♦When did this episode start? _____
♦Is this your first episode? □ Yes □ No
♦Did this start after trauma/fall? □ Yes □ No
♦What % of the day do you feel this pain? _____%
♦Pain intensity at its worst? (1-10): _____
♦Describe your pain: (circle all that apply or use your own description)
*achy sharp burning numb tingling pins+needles*
other: _____
♦List the top 2 position/movements that make it worse.
1. _____
2. _____
♦List the top 2 position/movements that relieve it.
1. _____
2. _____
♦Comments/Concerns?
_____
_____
_____

Intake Form 2

Name: _____

## Review of Systems

Additional health concerns?

| No | Yes | |
|---|---|---|
| | | Muscle, Bones or Joints |
| | | Nerves, Headache, Dizziness, or Emotional |
| | | Head, Eyes, Ears, Nose or Throat |
| | | Heart, Blood Pressure, or Circulation |
| | | Shortness of Breath, Coughing, Asthma or Lung Conditions |
| | | Stomach, Bowel, or Digestive Conditions |
| | | Genital, Bladder, or Urinary Conditions |
| | | Diabetes, Thyroid, or Glandular Conditions |
| | | Skin or Bleeding Conditions |
| | | Bruise Easily |

♦ Prior Imaging/tests? (MRI, X-rays, CT scan, Nerve tests, etc.)

□ *No* □ *Yes, Explain:* _____

♦ Prior treatment? (List type of provider and approximate number of visits. Ex. Physical therapy 20 visits)

□ *No* □ *Yes, Explain:* _____

♦ Surgical procedures?

□ *No* □ *Yes, Explain:* _____

♦ Past Traumas? (Car accidents, falls, broken bones, sprains, etc.)

□ *No* □ *Yes, Explain:* _____

♦ Past or current medical conditions?

□ *No* □ *Yes, Explain:* _____

♦ Prescription Medications?

□ *No* □ *Yes, List:* _____

♦ Over the counter medications including supplements?

□ *No* □ *Yes, List:* _____

## Family History (Blood relatives: Parents, Grandparents, Siblings)

| | | | | |
|---|---|---|---|---|
| □ Arthritis | □ Cancer | □ Neurological | □ Diabetes | □ Heart Problems |
| □ Disc Herniation | □ Low back/neck pain | □ Stroke | □ Thyroid | □ Other _____ |

Patient or Legal Guardian Signature_____ Date:_____