Barnewolt & Barnewolt Chiropractic, P.C.

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: Date: (mm/dd/yr)

Address:

☐male☐female

Marital Status
S M W D Sep

Home# Work# Cell#

E-mail address:

Occupation: Employer:

Mark ☒ for current problems, Mark ☑ for past problems and indicate your age

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss/gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruises easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose, and Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore Throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination:
- ☐ Overnight more than twice
- ☐ More than 8x in 24 hours
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid Heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breasts
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐Pain/cramps
Days of flow: Length of cycle:
Date-1st day last period:
Pregnant? ☐ Yes ☐ No
How many months?
How many children?
Birth control method?
Date last PAP?
☐ Normal ☐ Abnormal
Date last mammogram
☐ Normal ☐ Abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications you are taking and why:

Doctor initials:_____Date:_____

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Patient Intake Form (Side 2)

Provide a brief description of the problem you are currently experiencing: _____

How long have you had this condition? _____ Is it getting worse? ☐Yes ☐No _____

Does it bother you (check appropriate box) ☐ Work ☐ Sleep ☐ Other: _____

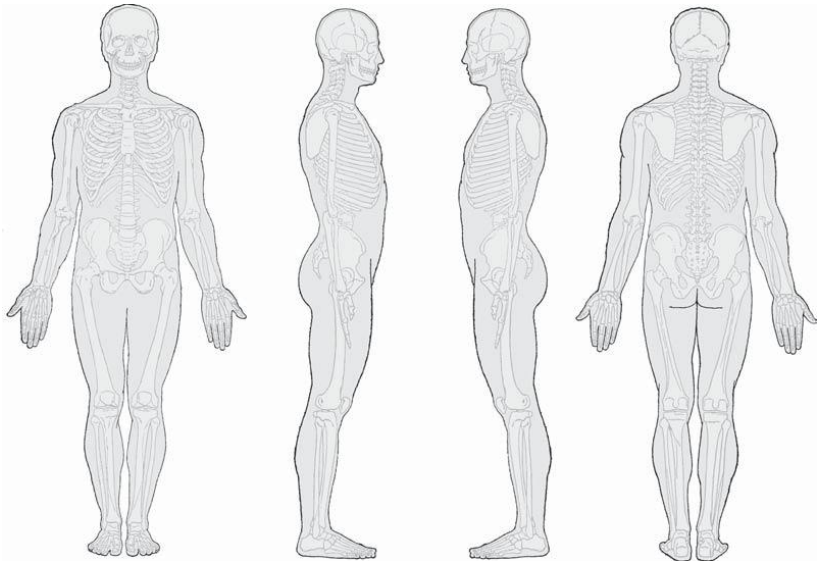
What seemed to be the initial cause? _____

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain

Please mark your areas of pain on the figure below



Health History

Have you…	Yes	No	Explain
…Been hospitalized in last 5 years?	☐	☐	
…had any mental disorder?	☐	☐	
…had any broken bones?	☐	☐	
…had any sprains or strains?	☐	☐	
…ever used orthotics?	☐	☐	
Do you take minerals, herbs, vitamins?	☐	☐	

How is most of your day spent? ☐ standing ☐ sitting ☐ other: _____

How old is your mattress? _____

When was your last physical exam?

Habits	none	light	mod.	heavy
alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family History

If any blood relative has had any of the following conditions, please indicate with a ☑.

☐ Alcoholism	☐ Bleed easily	☐ Glaucoma	☐ Multiple sclerosis
☐ Anemia	☐ Cancer	☐ Heart disease	☐ Osteoporosis
☐ Arteriosclerosis	☐ Diabetes	☐ High blood pressure	☐ Stroke
☐ Arthritis	☐ Emphysema	☐ High cholesterol	☐ Thyroid disease
☐ Asthma	☐ Epilepsy		

Do you have any other health issues or concerns that our staff should be made aware of? _____

Doctor initials:_____Date:_____