BELLTOWN SPINE & WELLNESS

PATIENT INTAKE FORM

DATE:

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	MARITAL STATUS (CHECK ONE) ☐ SINGLE ☐ MAR ☐ DIV ☐ SEP ☐ WID		
IS PATIENT A MINOR? ☐ YES ☐ NO	IF **YES**, WHO IS THE LEGAL GUARDIAN/PARENT RESPONSIBLE FOR PATIENT?		PATIENT BIRTH DATE:	AGE:	SEX: ☐ M ☐ F
HEIGHT:	WEIGHT:	HANDED: ☐ RIGHT ☐ LEFT ☐ BOTH			

CONTACT INFORMATION

ADDRESS:		APT NO:	HOME PHONE:
CITY:	STATE:	ZIP:	CELL PHONE:
OCCUPATION:	EMPLOYER:		WORK PHONE:
EMAIL ADDRESS:			
EMERGENCY CONTACT NAME:	PHONE #:	RELATIONSHIP:	
REFERRED TO CLINIC BY (PLEASE CHECK ONE BOX): ☐ FAMILY/FRIEND/CO-WORKER/PATIENT (NAME):			
☐ EVENT ☐ WALK-IN ☐ LOCATION ☐ SOCIAL MEDIA ☐ INTERNET (WHICH SITE?):			
WE PROVIDE AUTOMATIC APPOINTMENT REMINDERS VIA TEXT AND EMAIL ☐ OPT OUT TEXT ☐ OPT OUT EMAIL			

INJURIES/SURGERIES

HAVE YOU EVER SUSTAINED A FALL OR INJURY THAT HAS REQUIRED MEDICAL ATTENTION? ☐ YES ☐ NO	
PLEASE COMPLETE THE FOLLOWING WITH AN APPROXIMATE DATE AND A BRIEF DESCRIPTION.	
FALL/HEAD INJURIES/BROKEN BONES:	DATE:
SURGERIES:	DATE:
WORK INJURIES:	DATE:
AUTO ACCIDENTS:	DATE:

REASON FOR VISIT

DESCRIBE THE PURPOSE OF THIS VISIT:	
WHEN AND/OR HOW DID THIS CONDITION BEGIN?	
HAS THE CONDITION: ☐ GOTTEN WORSE ☐ STAY CONSTANT ☐ COMES & GOES	
HAS THIS CONDITION OCCURRED BEFORE? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN:

(PLEASE SEE REVERSE SIDE)

CHIROPRACTIC HISTORY

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO	DOCTOR'S NAME:
APPROXIMATE DATE OF LAST ADJUSTMENT:	APPROXIMATE DATE OF LAST X-RAY:

HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION? ☐ MEDICATIONS ☐ SURGERIES ☐ CHIROPRACTIC ☐ NONE ☐ OTHER (PLEASE INDICATE):

PRIMARY CARE PHYSICIAN:	DATE OF LAST PHYSICAL EXAM:

HEALTH REVIEW

PLEASE CHECK ALL THAT APPLY

☐ UNEXPECTED WEIGHT LOSS OR GAIN	☐ JOINT PAIN	☐ NUMBNESS
☐ BLURRED/DOUBLE VISION	☐ SKIN RASH	☐ HERNIATED DISCS
☐ HEADACHE/MIGRAINE	☐ DIZZINESS	***(WOMEN ONLY)***
☐ CHEST PAIN	☐ DEPRESSION/ANXIETY	☐ PREGNANT
☐ SHORTNESS OF BREATH	☐ EASY BRUISING	☐ MENSTRUAL CRAMPS
☐ NAUSEA	☐ EXCESSIVE THRIST OR URNIATION	☐ BREAST IMPLANTS
☐ PAINFUL URNIATION/FREQUENT	☐ REACTION TO FOODS/ENVIRONMENT	

☐ PLEASE LIST ALL OTHER CONDITIONS _____

DO YOU CONSUME ALCOHOL? ☐ I DO NOT DRINK ☐ I DRINK MODERATELY ☐ I DRINK OCCASIONALLY

DO YOU SMOKE? ☐ YES ☐ NO ☐ I PREVIOUSLY SMOKED

HAVE YOU OR ANYONE IN YOUR IMMEDIATE FAMILY EVER HAD THE FOLLOWING?

☐ CANCER	☐ HYPERTENSION	☐ DIABETES
☐ STROKE	☐ OTHER (PLEASE INDICATE): _____	

MEDICATIONS

MEDICATIONS CURRENTLY TAKING:
ALLERGIES (IF ANY):
VITAMINS/HERBS/MINERALS:

PERSONAL LIFESTYLE

EXERCISE	**WORK ACTIVITY**	**STRESS LEVEL**	**SLEEP**
☐ NONE	☐ SITTING	☐ LOW	☐ STOMACH
☐ 1-2X WEEK	☐ STANDING	☐ MEDIUM	☐ SIDE
☐ 3-4X WEEK	☐ LIGHT LABOR	☐ HIGH	☐ BACK
☐ 5+X WEEK	☐ HEAVY LABOR	STRESS CAUSES:	☐ TWIST/TURN

TYPE OF EXERCISE:

HOW WOULD YOU RATE YOUR DIET? ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT

HOW WOULD YOU RATE YOUR HEALTH? ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT

SIGNATURE: _____ DATE: _____