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

PATIENT INTAKE FORM FOR CARE AT NONA FUNCTIONAL CHIROPRACTIC

Today's Date: _____ CTN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐Male ☐Female

Address: _____

City: _____State: ___ _ Zip: _____ E-mail: _____

Home Phone: _____Mobile Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐Married Spouse's Name _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

Please identify the condition(s) that brought you to this office:

Primarily:_____ Secondarily:_____

For Administrative Use Only

Patient's Name: _____ CT#: _____ ____/____/____

Third: _____ Fourth: _____

Name of Previous Chiropractor: _____ Last Visit Date: _____

SOCIAL HISTORY

1. **Smoking**: ☐cigar ☐pipe ☐cigarettes → How often? ☐Daily ☐Weekends ☐Occasionally ☐Never
2. **Alcoholic beverage**: consumption occurs → ☐Daily ☐Weekends ☐Occasionally ☐Never
3. **Recreational drug use**: ☐Daily ☐Weekends ☐Occasionally ☐Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐No ☐ Yes

   If yes whom: ☐grandmother ☐grandfather ☐mother ☐father

   ☐sister's ☐brother's ☐son(s) ☐daughter(s)

   Have they ever been treated for their condition? ☐ No ☐ Yes ☐I don't know
2. Any other hereditary conditions the doctor should be aware of?

   ☐ No ☐Yes: _____

I hereby authorize payment to be made directly to Lake Nona Functional Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Lake Nona Functional Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

For Administrative Use Only

Patient's Name: _____ CT#: _____ ____/____/____

Activities of Daily Living/Symptoms/Medications

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache
___ Pregnant (Now)
___ Dizziness
___ Prostate Problems
___ Ulcers
___ Neck Pain
___ Frequent Colds/Flu
___ Loss of Balance
___ Impotence/Sexual Dysfun.
___ Heartburn
___ Jaw Pain, TMJ
___ Convulsions/Epilepsy
___ Fainting
___ Digestive Problems
___ Heart Problem
___ Shoulder Pain
___ Tremors
___ Double Vision
___ Colon Trouble
___ High Blood Pressure
___ Upper Back Pain
___ Chest Pain
___ Blurred Vision
___ Diarrhea/Constipation
___ Low Blood Pressure
___ Mid Back Pain
___ Pain w/Cough/Sneeze
___ Ringing in Ears
___ Menopausal Problems
___ Asthma
___ Low Back Pain
___ Foot or Knee Problems
___ Hearing Loss
___ Menstrual Problem
___ Difficulty Breathing
___ Hip Pain
___ Sinus/Drainage Problem
___ Depression
___ PMS
___ Lung Problems
___ Back Curvature
___ Swollen/Painful Joints
___ Autism Spectrum
___ Bed Wetting
___ Kidney Trouble
___ Scoliosis
___ Skin Problems
___ Ear Infections
___ Learning Disability
___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers
___ ADD/ADHD
___ Eating Disorder
___ Liver Trouble
___ Numb/Tingling legs, feet, toes
___ Allergies
___ Trouble Sleeping
___ Hepatitis (A, B, C)

List Prescription & Non-Prescription drugs you take:_____

_____

_____

_____

_____

For Administrative Use Only

Patient's Name: _____ CT#: _____ ____/____/____

_____

Initial Central Nervous System Profile

When was your most recent auto accident (Date)? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe_____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury_____

Was treatment received? Please describe_____

Does your job require you remain in long term stressful postures? _____

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track _____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out