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 _____

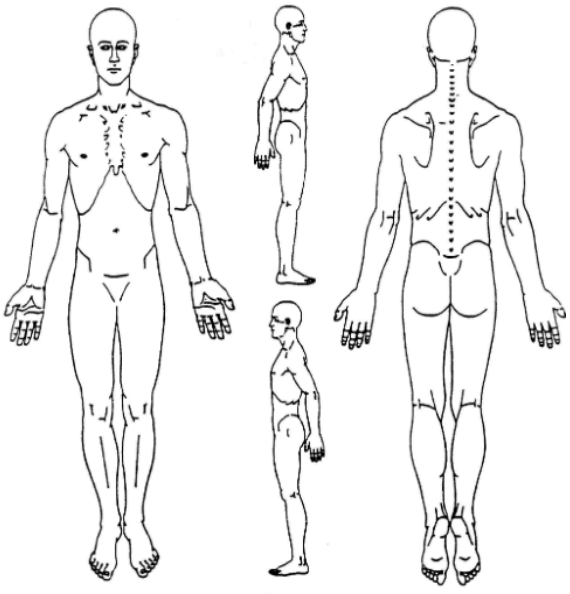
Patient Information

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)

Fill in the location of your pain below.



How would you describe the pain?
_____

Pain intensity at its worst? (1-10): _____

What makes this worse?
_____

What makes this better?
_____

When did this first start? _____

Intake Form 2

Name: _____

Review of Systems (Check all that apply)

□ Recent fever, infection, or chills □ Dizziness or Vertigo □ Unexplained weight loss or gain □ Smoker

Are you having problems with: □ Vision □ Digestion □ Breathing □ Bowel or bladder function □ Heart/Circulation □ Skin

Medications: _____

_____

Supplements: _____

Surgeries/broken bones: _____

Dr's notes leave blank

Health History/Medical Conditions (Check all that apply)

□ Alcoholism	□ Chicken Pox	□ Headache	□ Miscarriage	□ Ringing in Ears
□ Anemia	□ Chronic Fatigue	□ Heart/Vascular Disease	□ Multiple Sclerosis	□ Scoliosis
□ Anorexia/Bulimia	□ Depression/Anxiety	□ Hepatitis	□ Neurological Condition	□ Skin Disorders
□ Arthritis	□ Diabetes	□ Hernia	□ Osteoporosis	□ Stroke
□ Asthma	□ Emphysema	□ Herniated Disk	□ Pacemaker	□ Thyroid Problems
□ Back/Neck Condition	□ Epilepsy	□ High Blood Pressure	□ Parkinson's Disease	□ Tuberculosis
□ Bleeding Disorders	□ Eye Condition	□ High Cholesterol	□ Pinched Nerve	□ Ulcers
□ Breast Lump	□ Fibromyalgia	□ Kidney Disease	□ Polio	□ Urinary Tract Infections
□ Cancer	□ Fractures	□ Liver Disease	□ Prostate Problems	□ Venereal Disease
□ Chemical Dependency	□ Gall Bladder Disease	□ Lupus	□ Prosthesis	□ Other _____
□ Chest Pain	□ Gout	□ Lyme Disease	□ Psychiatric Illness	□ Other _____

Family History (Check all that apply)

□ Arthritis	□ Cancer	□ Cholesterol	□ Diabetes	□ Heart Problems
□ High blood pressure	□ Psychiatric	□ Stroke	□ Thyroid	□ Other _____

Patient or Legal Guardian Signature_____ Date:_____