WELCOME TO OUR OFFICE

Name _____ Age ___ Date of Birth ____/____/____

Address _____ City _____ Zip _____

E-mail _____ Home Phone_____

Cell Phone _____ Work Phone _____

Preferred Method of Contact (check one): Home Phone Cell Phone Work Phone

Occupation: _____ Employer: _____

Marital Status: ___Single ___Married ___Divorced ___Separated ___Widow ___Widower

Name of Spouse_____Occupation_____

How did you hear about us? Who may we thank for referring you? _____

HEALTH CARE PRACTICIONER HISTORY

Current Primary Care Physician: _____

City: _____ State: _____

Have you ever received chiropractic care? __Y __N Name of D.C._____

Last visit to this chiropractor: _____

Reason for Leaving: _____

REASONS FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Lakeville Chiropractic can address for you? _____

_____

FOR WOMEN

Are you pregnant? ___Y ___N

If x-rays are recommended your signature is required (below) to indicate that you are **not pregnant.**

Signature _____ Date_____

If pregnant, Due Date _____ OBGYN or Midwife _____

ADULT CONSULTATION HISTORY

Main complaint (if no complaint just write "Wellness")_____

Any other complaints:_____

_____

How long have you suffered with this problem?_____

Do you know how this problem began?_____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does the problem interfere with the following areas of your life?
Work: _____

Family: _____

Hobbies: _____

Life: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

_____

What gives you some temporary relief? _____

How much older does this make you feel? _____

What is the pattern of this problem? (circle one) Constant Daily Off & On Weekly

What is the effect it has on your body functions? _____

On a scale of 1-10, with 10 being the highest, rate your commitment in helping us solve this problem: ___

Is this problem (circle one): getting better getting worse staying the same

Rate your discomfort (circle one). 0 is no pain, 10 is the worst pain: 0 1 2 3 4 5 6 7 8 9 10

HEALTH INFORMATION AND HEALTH HISTORY

List your hobbies: 1)_____ 2)_____ 3)_____

What are your habits?

Smoking	never	packs per day _____
Alcohol	never	drinks per day_____
Caffeinated Drinks	never	drinks per day_____
Exercise	never	times per week_____
Drug/Substance Abuse	never	Yes, if yes discuss with the doctor

MEDICAL HISTORY

Have you been hospitalized in the past five years? ___Yes ___No
Date (approximate) and Reason:
_____

Have you had any serious accidents in the past five years: ___Yes ___No
Date and Describe: _____

Any surgeries: _____

In <u>the past 6 months</u> have you suffered from: Circle all that apply, or circle normal

General:	Fatigue	Weakness	Weight change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Vision:	Dryness	Redness	Cataract	Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Hypertension Palpitations	Sneezing	Wheezing	Chest Pain	Normal
Gastrointestinal:	Diarrhea Constipation	Vomiting Gas	Appetite Change	Heartburn	Normal
Endocrine:	Goiter	Diabetes	Heat Intolerance	Cold Intolerance	Normal
Psychologic:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

Have you <u>ever had any of the following</u>: Circle all that apply

Arthritis	Heart Trouble	Pacemaker	Diabetes	Epilepsy
Dislocated Joints	Hay Fever	Asthma	Bone Fracture	Tuberculosis
High blood pressure	Serious Injury	Allergies	Low blood pressure	Polio
Prostate Trouble	Sinus Trouble	Rheumatic Fever	Kidney Trouble	Scoliosis
Spinal Disease	Cancer	Thyroid Trouble	HIV/Aids	Ulcer
STD	Stroke	Depression	Anxiety	Pacemaker

Do you have any children? _____

What are their ages? _____

Do they have any problems that you are aware of? _____

_____

Is there any other health information you would like us to know? _____

_____

_____

_____

_____

PLEASE READ AND SIGN BELOW

The information I have provided on this form, is true and accurate to the best of my knowledge. I give Dr. Michael P. Griffin permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation. I also give my consent to have the doctor order any x-rays that he deems appropriate, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature_____ Today's Date_____

Signature of Parent (for minor):_____ Today's Date_____

Thank you for choosing Lakeville Chiropractic.

"My mission is to help as many people in my lifetime as possible, especially children."

-Michael Griffin, DC

Lakeville Chiropractic

Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Text Message

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

☐ **Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

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Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

☐ **Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

☐

Do you have any *medication* allergies? ___ No ___Yes

Medication Name	Reaction	Onset Date	Additional Comments

☐

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

☐

Height: _____ Weight:_____ Blood Pressure:_____ /_____