Finesse Chiropractic

Dr. Marvin Kunikiyo

New Patient Intake Form

PATIENT INFORMATION:

Name (Last, First): _____ DOB (MM/DD/YY): _____

Today's Date (MM/DD/YY) _____ Age: _____ Sex (M/F): _____

Phone #: _____ E-mail: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Marital Status: ___ Married ___ Partnership ___ Single ___ Divorced ___ Widowed

Children: ____ Number Names & Ages _____

Spouse/Partner's Name: _____

How did you hear about us? _____

BRIEF HEALTH HISTORY:

What is your primary health challenge that you are seeking help with? _____

What is the date this health challenge started? (MM/DD/YY): _____

Is your health challenge:

___ Getting better ___ Staying the same ___ Getting worse

Have you had previous chiropractic care for this particular health challenge (Y/N)? _____

Have you seen your medical doctor for your current health challenge (Y/N)? _____

What activities make your health challenge worse? _____

What, if anything, makes your current health challenge better? _____

Do you take any medications/pain relievers for your current health challenge (Y/N)? _____

If yes, please list them: _____

Patient Signature: _____ Date: _____

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Lifestyle & Health

On a scale of 1-10, how important is it to you to be as healthy as you can be? _____

On a scale of 1-10, what is your energy level on a day-to-day basis? _____

On a scale of 1-10, what in your stress level on a day-to-day basis? _____

Approximately how many hours of sleep do you get per night? _____

Do you exercise? _____ If so, how many days per week? _____

Do you partake in any physical recreational activities (i.e. sports, hiking, cycling)? _____

_____

How many ounces of water do you drink per day? _____

Do you consume fast food? _____ If so, how many days per week? _____

Do you drink coffee or tea in the morning? _____ Black or with sugar/cream? _____

How many ounces daily? _____

Do you consume energy drinks? _____ If so, how many days per week? _____

Do you consume soda? _____ If so, how many days per week? _____

Do you consume alcohol? _____ If so, how many days per week? _____

How many drinks? _____

Do you smoke cigarettes? _____ If so, how many per day? _____

Do you take any prescription drugs? _____

If so, please list all medications below along with the daily dosage:

MEDICATIONS:	DOSAGE/FREQUENCY:

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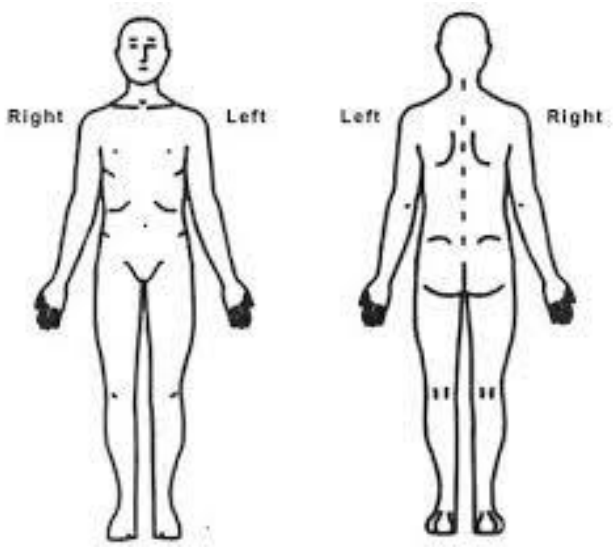
Pain Diagram & Medical History

Please indicate on the diagram below by circling and labeling the locations in which you are currently experiencing pain.

Is the pain…

A. Ache
T. Tingling
N. Numbness
B. Burning
S. Shooting
F. Fatigue
O. Other



How often do you experience these symptoms?

___ Constantly (76-100% of the day)
___ Frequently (51-75% of the day)
___ Intermittently (26-50% of the day)
___ Occasionally (0-25% of the day)

Have you had an auto accident or near accident, even as a passenger?
___ Yes ___ No

If yes, when? _____

Please describe:
_____
_____
_____

Have you ever been diagnosed with a serious disease?
___ Yes ___ No

If yes, what/when? _____

Have you ever been knocked unconscious or sustained any head injuries?
___ Yes ___ No

If yes, when? _____

Please describe:
_____
_____
_____

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Pain Diagram & Medical History

Have you ever had any surgeries?
___ Yes ___ No

If yes, when and what for? _____

Please check to indicate if you have ever experienced or are currently experiencing the following conditions:

___ Diabetes
___ Asthma
___Chest Pain
___ Hepatitis
___Stroke
___Emphysema
___ Tuberculosis
___Coronary Artery Disease
___Arrhythmia
___Kidney Stones
___Parkinson's
___Cough
___Menopausal
___Sweating
___HIV/AIDS
___ Bowel Problems
___Liver Issues
___Nausea/Vomiting
___Osteoporosis
___Lower Back Pain
___Shoulder Pain
___ Eye problems – type: _____
___Other, please explain: _____

___ High blood pressure
___ Heart attack
___Kidney disease
___ Thyroid disease
___Depression
___Seizures
___Anxiety
___Congestive Heart Failure
___Irregular/Painful Urination
___Migraines/Headache
___Vertigo
___Shortness of Breath
___Fever/Chills
___Immune Disorder
___Dizziness
___Constipation
___Ulcers
___Arthritis
___Neck Pain
___Upper Back Pain
___Joint Replacement
___ Cancer – type: _____

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Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that **I am** responsible for any payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient (or Guardian's) Signature Date (MM/DD/YYY)