

**Peters Wellness Chiropractic, Inc.**  
**Intake Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Website: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Marital Status:  S  M  W  D Sex:  M  F Number of children: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
Your Occupation: \_\_\_\_\_ Your Employer: \_\_\_\_\_ Year's Employed: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Reason for today's visit:  Emergency  New Injury  Old Injury  Chronic Pain  Wellness Visit

**Describe your Primary Complaint:** \_\_\_\_\_

Date Initial Symptoms Began: \_\_\_\_\_ and mode of initial onset: \_\_\_\_\_

Date of Recent Exacerbation: \_\_\_\_\_ and mode of recent exacerbation: \_\_\_\_\_

Duration / Frequency:  Occasional (0-25% of day),  Intermittent (26-50% of day),  Frequent (51-75% of day),  Constant (76-100%)

Duration Notes: \_\_\_\_\_

Characterization:  Dull,  Sharp,  Radiating,  Local,  Deep,  Superficial

Characterization Notes: \_\_\_\_\_

Intensity:  Minimal,  Mild,  Moderate,  Severe

Rate/Circle your pain on the following scale (1 is minimal & 10 is Severe): Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

What Exacerbate/Worsens your condition: \_\_\_\_\_

What Ameliorates/Lessens your condition: \_\_\_\_\_

Are there any other related symptoms: \_\_\_\_\_

Did your injury occur during:  Auto Accident,  Work Related,  Sports/Play,  Routine/Household Activity *If your injury is work or auto related please fill out the appropriate form located on the website under optional forms.*

Where were you when injury occurred? \_\_\_\_\_

Please explain what happened: \_\_\_\_\_

Is your condition getting worse?  Yes,  No

Is your condition interfering with your:  Work,  Sleep,  Daily Routine If so, how: \_\_\_\_\_

Has this or something similar happened in the past?  Yes,  No If yes, explain: \_\_\_\_\_

Are you taking any medications?  Yes,  No If yes, what: \_\_\_\_\_

Are you taking any non-prescription drugs?  Yes,  No If yes, what: \_\_\_\_\_

**Describe Additional Complaint #1:** \_\_\_\_\_

Date Initial Symptoms Began: \_\_\_\_\_ and mode of initial onset: \_\_\_\_\_

Date of Recent Exacerbation: \_\_\_\_\_ and mode of recent exacerbation: \_\_\_\_\_

Duration / Frequency:  Occasional (0-25% of day),  Intermittent (26-50% of day),  Frequent (51-75% of day),  Constant (76-100%)

Duration Notes: \_\_\_\_\_

Characterization:  Dull,  Sharp,  Radiating,  Local,  Deep,  Superficial

Characterization Notes: \_\_\_\_\_

Intensity:  Minimal,  Mild,  Moderate,  Severe

Rate/Circle your pain on the following scale (1 is minimal & 10 is Severe): Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

What Exacerbate/Worsens your condition: \_\_\_\_\_

What Ameliorates/Lessens your condition: \_\_\_\_\_

Are there any other related symptoms: \_\_\_\_\_

**Any Other Complaint(s):** \_\_\_\_\_

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Have you seen other doctor's for the above condition(s)? If yes please fill in information below: \_\_MD, \_\_DC, \_\_DO, \_\_DDS

Doctor 1: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ X-rays: \_\_\_\_\_

Treatment: \_\_Medication, \_\_Physiotherapy, \_\_Other: \_\_\_\_\_

Results: \_\_\_\_\_ Length of time under care: \_\_\_\_\_

Doctor 2: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ X-rays: \_\_\_\_\_

Treatment: \_\_Medication, \_\_Physiotherapy, \_\_Other: \_\_\_\_\_

Results: \_\_\_\_\_ Length of time under care: \_\_\_\_\_

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

Y N Sensitivity to Light	Y N Migraines/Headaches	Y N Epilepsy	Y N Irritability	Y N Multiple Sclerosis	Y N Depression
Y N Ringing in Ears	Y N Dizziness/Fainting	Y N Thyroid Issues	Y N Neck Pain	Y N Arm Numbness	Y N Mood Swings
Y N Psychiatric Problems	Y N Sinus Problems	Y N Glaucoma	Y N Fatigue	Y N Arteriosclerosis	Y N Asthma
Y N Gallbladder Issues	Y N Heartburn/Gastric Reflux	Y N Pleurisy	Y N Pneumonia	Y N Rheumatic Fever	Y N Tuberculosis
Y N Mid-Back Pain	Y N Heart Attack/Stroke	Y N Shingles	Y N Heart Surgery	Y N Pace Maker	Y N H or L Blood Pressure
Y N Alcohol/Drug Use	Y N Chemo Therapy	Y N Cancer	Y N Heart Murmur	Y N Hepatitis	Y N Anemia
Y N Diabetes	Y N Kidney Problems	Y N Allergies	Y N Constipation	Y N Leg Numbness	Y N Hot Flashes
Y N Diarrhea	Y N Polio	Y N Ulcers	Y N Urinary Issues	Y N Menstrual Cramping	Y N Irregular Periods
Y N Venereal Disease	Y N Recurring Stomach Issues	Y N Arthritis	Y N Low Back Pain	Y N Artificial Joints	Y N Artificial Implants

Personal History Notes: \_\_\_\_\_

List surgical operations and dates: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Family Health History (Grand Parents/Parents/Brothers/Sisters): \_\_\_\_\_

Immediate Family Deaths: \_\_\_\_\_

Do you take dietary supplements or vitamins? \_\_Yes, \_\_No If yes, what kind: \_\_\_\_\_

Do you exercise? \_\_Yes, \_\_No If yes, # of hours per week: \_\_\_\_\_ Do you wear: \_\_Arch Supports/Orthotics

Do you smoke? \_\_Yes, \_\_No If yes, how much: \_\_\_\_\_ For how long: \_\_\_\_\_

Are you dieting? \_\_Yes, \_\_No If so, since: \_\_\_\_\_

**WOMEN:** Are you taking birth control? \_\_Yes, \_\_No Are you pregnant? \_\_Yes, \_\_No Are you nursing? \_\_Yes, \_\_No

**Financial Responsibility:**

Person Responsible For Payment: \_\_\_\_\_

How will payments be made: \_\_Cash, \_\_Check, \_\_Credit Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Please provide your insurance card(s) to the receptionist.

Are you covered by Medicare? \_\_Yes, \_\_No If yes, please provide your Medicare card to the receptionist.

Who may we thank for referring you to us or how did you hear about us: \_\_\_\_\_

All of the above is accurate to the best of my knowledge (please sign): \_\_\_\_\_ Date: \_\_\_\_\_

I, parent/guardian, give permission for minor's care (please sign): \_\_\_\_\_ Date: \_\_\_\_\_