REVIVE
CHIROPRACTIC

## New Patient Intake

Name: _____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____-_____ Work: ( )_____-_____ Cell: ( ) _____-_____

For text messages reminders. Who is you cell phone carrier? _____

Email Address: _____ Social Security Number: _____

Birth Date: _____ Age: _____ Marital Status: _____ Spouse's name: _____

Are you or your spouse an Active member/ Veteran of the Military: Yes / No

Occupation: _____ Employer Name: _____

Insurance: Primary _____ Secondary_____ Do you have one of the following? HSA/Flex

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Primary Insurance Beneficiary: Self / Spouse / Parent Name: _____ DOB: _____

Have you seen a chiropractor before? Yes / No If yes, when? _____

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

# YOUR HEALTH HISTORY

Main complaint: _____

List any medications you are taking: _____

List any previous surgeries: _____

_____

Have you been in a car accident recently? Yes / No If so, when? _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____
The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Office Use only. Patient ID: _____

# Functional Rating Index

Regarding your MAIN COMPLAINT.

In order to properly assess your condition, we must understand how much your main complaint has affected your ability to manage everyday activities.

For each of the items below, please circle the one choice which most closely describes your condition right now.

**Pain Intensity**
0) No pain
1) Mild pain
2) Moderate pain
3) Severe pain
4) Worst possible pain

**Sleeping**
0) Perfect sleep
1) Mildly disturbed sleep
2) Moderately disturbed sleep
3) Greatly disturbed sleep
4) Totally disturbed sleep

**Personal Care (washing, dressing, etc.)**
0) No pain, No restrictions
1) Mild pain, No restrictions
2) Moderate pain; Need to go Slowly
3) Moderate pain; Need some Assistance
4) Severe pain; Need 100% Assistance

**Travel (driving, etc.)**
0) No pain on long trips
1) Mild pain on long trips
2) Moderate pain on long trips
3) Moderate pain on short trips
4) Severe pain on short trips

**Work**
0) Can do usual work plus unlimited extra work
1) Can do usual work, no extra work
2) Can do 50% of usual work
3) Can do 25% of usual work
4) Cannot work

**Recreation**
0) No pain
1) Mild pain
2) Moderate pain
3) Severe pain
4) Worst possible pain

**Frequency of Pain**
0) No pain
1) Occasional pain; 25% of the day
2) Intermittent pain; 50% of the day
3) Frequent pain; 75% of the day
4) Constant pain; 100% of the day

**Lifting**
0) No pain with heavy weight
1) Increased pain with heavy weight
2) Increased pain with moderate weight
3) Increased pain with light weight
4) Increased pain with any weight

**Walking**
0) No pain with any distance
1) Increased pain after 1 mile
2) Increased pain after ½ mile
3) Increased pain after ¼ mile
4) Increased pain with all walking

**Standing**
0) No pain after several hours
1) Increased pain after several hours
2) Increased pain after 1 hour
3) Increased pain after ½ hour
4) Increased pain with any standing

Patient Name: _____

Signature: _____ Date: _____

For Office Use Only:

Patient ID: _____ Total Score: _____

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITIES: | EFFECT: | | | |
|---|---|---|---|---|
| Carry Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climb Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lift Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Read/Concentrate | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Getting Dressed | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Shaving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sexual Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sleep | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static/Fixed Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static/Fixed Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Yard work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Washing/Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dishes | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Laundry | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Garbage | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

**List Prescription & Non-Prescription drugs you take: _____**

_____

_____

**Patient signature: _____ Today's Date: __/__/__**

Continued on next page

# REVIEW OF SYSTEMS

Please mark **P** for in the **Past, C** for **Currently** have, or **Leave Blank** 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 |
| ___ Hepatitis (A,B,C) | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disabilty | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Stroke |
| ___ Numb/Tingling legs, feet, toes | | ___ Allergies | ___ Trouble Sleeping | ___ Heart Attack |

**REGARDING:** X-rays/Imaging Studies

***FEMALES ONLY*** → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____

Patient or Authorized Person's Signature Date