Morsch Family Chiropractic
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New Patient Intake Form

Date: _____

Personal Information

Patient's Name: _____ Date of Birth: _____

Address: _____ City:_____ State: _____

Zip:_____ Email: _____

Home Phone: _____ Is it ok to leave a detailed message? ☐ Yes ☐ No
Cell: _____ Is it ok to leave a detailed message? ☐ Yes ☐ No
Work:_____ Is it ok to leave a detailed message? ☐ Yes ☐ No

Check if you are: ☐ Married/Domestic Partner ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Spouse/Partner: _____ Ages of Children: _____

Employment or School Information

Name and Address of Employer or School: _____

What are the physical requirements of your work or school? _____
_____

Name and Address of Spouse/Partner's Employer or School: _____

Employment/School Status:☐Full-Time ☐Part-Time ☐Other _____

Information Regarding Minors

If under 18, Parent/Legal Guardian's Name: _____

Parent/Guardian's signature for consent to treat a minor: _____

Medical and Emergency Contacts

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Home Phone: _____ Cell: _____
Family Physician: _____ Date of last visit: _____

Address: _____ Physician's phone number: _____

Who may we thank for referring you: _____

Insurance

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Insurance Company: _____

Policy #: _____ Group #: _____

Is patient covered by additional/secondary insurance? ☐ Yes ☐ No

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Insurance Company: _____

Policy #: _____ Group #: _____

Medical History

Height: _____ Weight: _____ ☐ Right – Handed ☐ Left – Handed

Occupation: _____

What brings you in today? _____

When did pain first occur? _____

How and where did it happen? _____

Have you had this problem before? _____

Work Related? ☐ Yes (If yes, do you plan to apply for Worker's Compensation?) _____
☐ No

Motor Vehicle Accident Related? ☐ Yes (If yes, will we be submitting to No Fault?) _____
☐ No

Describe the Pain: ☐ Sharp ☐ Pins & Needles ☐ Stiff ☐ Ache ☐ Burning ☐ Throbbing

☐ Other: _____

Does the pain radiate? If yes, where? _____

When does it hurt most? _____

Does it hurt to cough or sneeze? ☐ Yes ☐ No

On a scale of 1 -10, what is your pain at its BEST: _____ at its WORST: _____

Have you missed time from work? ☐ Yes ☐ No If yes, when did you work last? _____

Has your employer restricted your work? ☐ Yes ☐ No
If yes, what restrictions? _____

What activities are you unable to do because of your pain?

At work: _____

At home: _____

Have you had any imaging for this condition? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan
☐ Other _____

List all medications: _____
List all Vitamins/Supplements: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what do you do? _____

Which of the following aggravates your condition?

☐ Sitting Down ☐ Sitting for long periods ☐ Walking
☐ Standing ☐ Standing for long periods ☐ Laying down
☐ Body Movement ☐ Deep Breathing ☐ Sleeping
☐ Specific Movement/Motion(s): _____
☐ Other: _____

Which of the following relieves your condition?

☐ Sitting Down ☐ Walking ☐ Laying Down ☐ Massage
☐ Heat/Hot Shower ☐ Ice ☐ Sleeping ☐ Exercise
☐ Stretching
☐ Medications: _____
☐ Other: _____

What other professionals have you seen for treatment of this condition? _____
_____

Are you on any blood thinning agents? ☐ Yes ☐ No

Please list any previous surgeries:
1. _____ Date:_____
2. _____ Date: _____
3. _____ Date: _____

Previous/Current Orthopedic Problems:

_____
_____

Past Medical History – Please check all that apply:

General Symptoms: ☐ Recent weight gain/loss ☐ Blurred Vision ☐ Headache ☐ Fainting
☐ Problems with sleep ☐Nervousness ☐ Fatigue ☐ Dizziness
☐ Recent fever/infection ☐ Other _____

Endocrine: ☐ Diabetes ☐ Parathyroid ☐ Gout ☐ Liver
☐ Thyroid ☐ Pituitary
☐ Other _____
Have you ever been prescribed a steroid medication? ☐ Yes ☐ No Why? _____

HEENT: ☐ Head Injuries ☐ Hearing Problems ☐ Jaw/TMJ Problem
☐ Inability to taste ☐ Eye/Vision Problems ☐ Inability to Smell
☐ Problems Swallowing ☐ Problems with Speech
☐ Other: _____

Cardiovascular: ☐ Rapid Heartbeat ☐ Slow Heartbeat ☐ Blood Pressure Problem
☐ Poor Circulation ☐ Stroke ☐ Heart Attack
☐ Irregular Heart Beat ☐ Varicose Veins ☐ Ankle/Leg Swelling
☐ Other: _____

Pulmonary: ☐ Asthma ☐ Shortness of Breath ☐ Chronic Bronchitis
☐ COPD ☐ Other: _____

Gastrointestinal: ☐ Ulcers ☐ Hiatal Hernia ☐ Colitis
☐ Gall Bladder Problem ☐ Diverticulitis ☐ IBS
☐ Other: _____

Genitourinary: ☐ Kidney Stones ☐ Infections ☐ Bloody Urine
☐ Painful Urination ☐ Night-time Urination ☐ Prostate Problem
☐ Testicle Problem ☐ Uterine Problem ☐ Ovarian Problem

Neurology ☐ Pinched Nerves ☐ Numbness ☐ Restless Legs
☐ Other: _____

Emotional ☐ Depression ☐ Anxiety ☐ History of Abuse
☐ Other: _____

Skin ☐ Rashes ☐ Psoriasis ☐ Moles
☐ Hives ☐ Other: _____

Allergy/ ☐ Seasonal Allergies ☐ Allergies to Medication_____
Immunology ☐ Latex ☐ Anemia ☐ Cancer _____
☐ Autoimmune_____ ☐ Other: _____

Social History

Number of Cigarettes Daily: Currently: _____ Age Started: _____ Years Quit: _____
Alcohol Consumption: Drinks per week: _____
Caffeine Consumption: Drinks per day: _____ Type of drink: _____
Water Consumption: Glasses per day: _____
Substance Abuse: ☐ Currently ☐ In the Past ☐ None

Family History

Father – Current Age or Age at Death: _____ ☐ Alive ☐ Deceased
Serious Illnesses/Cause of Death: _____
Mother – Current Age or Age at Death Age: _____ ☐ Alive ☐ Deceased
Serious Illness/Cause of Death: _____
Brothers #_____ Serious Illnesses, if any: _____
Sisters # _____ Serious Illnesses, if any: _____
Any other family member with a similar condition: _____