



## Patient Intake Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when? \_\_\_\_\_

Name of most recent Chiropractor: \_\_\_\_\_

### 1. Reasons for seeking chiropractic care:

Primary reason: \_\_\_\_\_

Secondary reason: \_\_\_\_\_

### 2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 3. Past Health History:

#### A. Please indicate if you have a history of any of the following:

- Anticoagulant use    Heart problems/high blood pressure/chest pain    Bleeding problems  
 Lung problems/shortness of breath    Cancer    Diabetes    Psychiatric disorders  
 Bipolar disorder    Major depression    Schizophrenia    Stroke/TIA's    Other \_\_\_\_\_  
 None of the above

#### B. Previous Injury or Trauma:

\_\_\_\_\_

925 Hwy 55, Ste 103  
Hastings, MN 55033  
651-437-6778

Doctor Signature: \_\_\_\_\_

Dr. Bethanie Schatz, D.C.  
Dr. Ann Lohmann, D.C., RN

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Have you ever broken any bones? Which?  
\_\_\_\_\_

C. Allergies: \_\_\_\_\_

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____

## 4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer  Strokes/TIA's  Headaches  Cardiac disease  Neurological diseases
- Adopted/Unknown  Cardiac disease below age 40  Psychiatric disease  Diabetes
- Other \_\_\_\_\_  None of the above

Deaths in immediate family: \_\_\_\_\_  
Cause of parents or siblings death \_\_\_\_\_ Age at death \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Social and Occupational History:

A. Job description: \_\_\_\_\_

B. Work schedule: \_\_\_\_\_

C. Recreational activities:  
\_\_\_\_\_

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):  
\_\_\_\_\_

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### Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

Asthma/difficulty breathing  COPD  Emphysema  Other \_\_\_\_\_  None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

Heart surgeries  Congestive heart failure  Murmurs or valvular disease  Heart attacks/MIs  Heart disease/problems  Hypertension  Pacemaker  Angina/chest pain  Irregular heartbeat  Other \_\_\_\_\_  
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

Visual changes/loss of vision  One-sided weakness of face or body  History of seizures  One-sided decreased feeling in the face or body  Headaches  Memory loss  Tremors  Vertigo  Loss of sense of smell  
 Strokes/TIAs  Other \_\_\_\_\_  None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

Thyroid disease  Hormone replacement therapy  Injectable steroid replacements  Diabetes  
 Other \_\_\_\_\_  None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

Renal calculi/stones  Hematuria (blood in the urine)  Incontinence (can't control)  Bladder Infections  
 Difficulty urinating  Kidney disease  Dialysis  Other \_\_\_\_\_  None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

Nausea  Difficulty swallowing  Ulcerative disease  Frequent abdominal pain  Hiatal hernia  Constipation  
 Pancreatic disease  Irritable bowel/colitis  Hepatitis or liver disease  Bloody or black tarry stools  
 Vomiting blood  Bowel incontinence  Gastroesophageal reflux/heartburn  Other \_\_\_\_\_  None of the above

Have you had any of the following **hematological (blood-related)** issues?

Anemia  Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)  HIV positive  
 Abnormal bleeding/bruising  Sickle-cell anemia  Enlarged lymph nodes  Hemophilia  
 Hypercoagulation or deep venous thrombosis/history of blood clots  Anticoagulant therapy  Regular aspirin use  
 Other \_\_\_\_\_  None of the above

Have you had any of the following **dermatological (skin-related)** issues?

Significant burns  Significant rashes  Skin grafts  Psoriatic disorders  Other \_\_\_\_\_  None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

Rheumatoid arthritis  Gout  Osteoarthritis  Broken bones  Spinal fracture  Spinal surgery  Joint surgery  
 Arthritis (unknown type)  Scoliosis  Metal implants  Other \_\_\_\_\_  None of the above

Have you had any of the following **psychological** issues?

Psychiatric diagnosis  Depression  Suicidal ideations  Bipolar disorder  Homicidal ideations  Schizophrenia  
 Psychiatric hospitalizations  Other \_\_\_\_\_  None of the above

Is there anything else in your past medical history that you feel is important to your care here? \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Power Within Chiropractic, P.A. for services performed.

Patient or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

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## NEW PATIENT HISTORY FORM

Symptom 1 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 2 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

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Symptom 3 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 4 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

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