# BodyMind Chiropractic and Functional Medicine Center

Confidential Patient Record

## Patient Intake Form

Patient Name:_____Date:_____

Address:_____City:_____State:_____Zip:_____

Date of Birth:____/____/_____Phone:_____Email:_____

Marital Status: ◯ Married ◯ Partner ◯ Single ◯ Divorced/Separated

Emergency Contact:_____Phone:_____Relationship:_____

Who referred you?_____

## Past Medical History

Significant Illnesses - Check any of the following you have had:

◯ Anemia ◯ Autoimmunity ◯ Digestive Issues ◯ Hormonal Issues

◯ Anxiety/Depression ◯ Cancer ◯ Heart Disease ◯ Migraine

◯ Arthritis ◯ Diabetes ◯ High Cholesterol ◯ Skin Conditions

◯ Other: _____

Surgeries: _____

Significant Trauma: _____

Allergies (drugs, chemicals, foods) _____

Significant Stressors:_____

## Medications and/or Nutritional Supplements

Name and Purpose

_____

_____

_____

_____

_____

## Current Health Condition

Please tell us what brings you in today:_____

_____

_____

_____

When did the condition begin? _____ Have you had it before? ◯ Yes ◯ No When? _____

Is the condition: ◯ Worsening ◯ Staying the same ◯ Improving ◯ Constant ◯ Intermittent

What makes the condition worse?_____

What makes the condition better?_____

Is this condition related to ◯ Automobile Accident ◯ Work Injury ◯ Traumatic injury _____

**Please indicate on the diagram the areas of your discomfort**

**Neck Pain**
0 1 2 3 4 5 6 7 8 9 10

**Shoulder/Arm Pain**
0 1 2 3 4 5 6 7 8 9 10

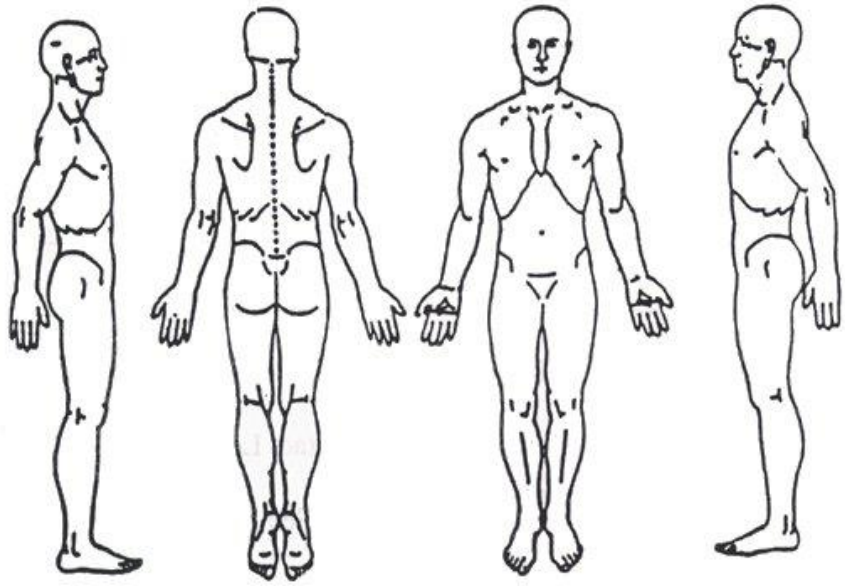
**Mid Back Pain**
0 1 2 3 4 5 6 7 8 9 10

**Low Back Pain**
0 1 2 3 4 5 6 7 8 9 10

**Hip/Leg Pain**
0 1 2 3 4 5 6 7 8 9 10

**Foot/Ankle Pain**
0 1 2 3 4 5 6 7 8 9 10

**Other Pain**_____
0 1 2 3 4 5 6 7 8 9 10



## Family Medical History

**Please check all that apply:**

◯ Alcoholism
◯ Alzheimer's/Parkinson's
◯ Anxiety/Depression
◯ Asthma/Allergies
◯ Autoimmunity
◯ Cancer
◯ Diabetes
◯ Heart Disease
◯ High Blood Pressure
◯ High Cholesterol
◯ Stroke
◯ Other_____

# Health Symptoms Questionnaire

**Rate each of the following symptoms based upon your typical health profile for the past 30 days**

**Point Scale:**

0 – Never/almost never have the symptoms
1 – Occasionally have it, effect is *not* severe
2 – Occasionally have it, effect is severe
3 – Frequently have it, effect is *not* severe
4 – Frequently have it, effect is severe

**Head**
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
_____TOTAL

**Eyes**
_____Watery or itchy
_____Swollen, reddened, or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
_____TOTAL

**Ears**
_____Itchy
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____TOTAL

**Nose**
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
_____TOTAL

**Mouth/Throat**
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen/discolored tongue, gums, lips
_____Canker sores
_____TOTAL

**Skin**
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating
_____TOTAL

**Heart**
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain
_____TOTAL

**Lungs**
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing
_____TOTAL

**Digestive Tract**
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching, passing gas
_____Heartburn
_____Intestinal/Stomach pain
_____TOTAL

**Joints/Muscle**
_____Pain or aches in joints
_____Arthritis
_____Stiffness or limitation of movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness
_____TOTAL

**Weight**
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight
_____TOTAL

**Energy/Activity**
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
_____TOTAL

**Mind**
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Poor physical coordination
_____Difficulty in making decisions
_____Stuttering or stammering
_____Slurred speech
_____Learning disabilities
_____TOTAL

**Emotions**
_____Mood swings
_____Anxiety, fear, nervousness, stress
_____Anger, irritability, aggressiveness
_____Depression
_____TOTAL

**Other**
_____Frequent illness
_____Frequent or urgent urination
_____Genital itch or discharge
_____TOTAL

**TOTAL** _____

## Lifestyle Habits

**Exercise**

◯ None
◯ 1 – 2 times per week
◯ 3 – 4 times per week
◯ 5 – 6 times per week
◯ Daily

**Work Activity**

◯ Sitting
◯ Standing
◯ Light Activity
◯ Moderate Activity
◯ High Activity

**Stress**

◯ Low Stress
◯ Moderate Stress
◯ High Stress

**Are you interested in stress management**: ◯ Yes ◯ No

**Eating Habits**

◯ Skip Breakfast
◯ 1 meal/day
◯ 2 meals/day
◯ 3 meals/day
◯ Graze all day

**Intake**

◯ Alcohol
◯ Coffee/Energy Drinks
◯ Recreational Drugs/Cigarettes
◯ Water
◯ Salt Craving ◯ Sugar Craving

**Quantity per Day**

_____
_____
_____
_____

**Sleep Habits**

Do you have difficulty falling asleep? ◯ Yes ◯ No Do you have difficulty staying asleep? ◯ Yes ◯ No

Do you awaken frequently during the night? ◯ Yes ◯ No If YES, what time do you awaken in the night? _____

Average number of hours of sleep per night _____ Do you feel rested when you wake up? ◯ Yes ◯ No

**Would you like to…**

◯ Have more energy
◯ Lose weight
◯ Sleep better
◯ Improve digestion
◯ Improve focus/memory
◯ Reduce effects of stress
◯ Decrease pain/increase mobility
◯ Reduce inflammation
◯ Reduce reliance on medication
◯ Other_____

I hereby authorize my treatment at BodyMind Chiropractic Center. I understand that all services rendered to me are my responsibility. When warranted, visits will be submitted to my insurance company. I understand that insurance coverage is not a guarantee of payment. Payment is due at the time of service.

**Patient Signature**:_____**Legal Guardian**:_____**Date:**_____