GREEN HILLS
Chiropractic Clinic

GREEN HILLS CHIROPRACTIC CLINIC
Your Chiropractic Family

2000 Glen Echo Rd, Suite 120
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Phone: 615-383-0244 | Fax: 615-386-3752

PATIENT INTAKE FORM

PATIENT INFORMATION

Date: _____

First Name: _____ **Last Name:** _____

Phone: _____ ☐ mobile ☐ home ☐ work ☐ other

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

DOB: _____ **Sex:** ☐ male ☐ female **Height:** _____' _____" **Weight:** _____ lbs

Employer Name: _____

Employer Phone: _____ **Occupation:** _____

How did you hear about us? ☐ walk in ☐ referral ☐ website ☐ insurance
☐ advertisement ☐ other: _____

Please list all surgeries:

_____
_____
_____

Please list all traumas:

_____
_____
_____

Complaints: *(list your chief complaint first)*

_____
_____
_____
_____

Do you know what caused the problem? _____

How often? _____ times per ☐ hour ☐ day ☐ constant

How long does it last? _____ ☐ minutes ☐ hours ☐ constant

When did symptom start? _____ ☐ days ☐ weeks ☐ months ☐ years

Intensity: ☐ slight ☐ mild ☐ moderate ☐ severe

Rate your pain on a scale of 0 to 10 *(0 being no pain at all and 10 being the worst pain imaginable)* _____

Describe your pain:

☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb
☐ swelling ☐ shooting ☐ stabbing ☐ stiff ☐ sharp ☐ tight
☐ tingling ☐ throbbing ☐ radiating

Aggravating Factors: What makes the problem worse?

☐ nothing ☐ most movements ☐ bending ☐ carrying things ☐ coughing
☐ driving ☐ going down stairs ☐ exercise ☐ housework ☐ eating
☐ going from lying to sitting ☐ going from lying to standing ☐ going from sitting to standing
☐ heat ☐ ice ☐ jogging ☐ lifting ☐ lying down ☐ massage
☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing
☐ squatting ☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching
☐ turning ☐ twisting ☐ taking a deep breath ☐ walking ☐ working

Relieving Factors: What makes the problem better?

☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation
☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers
☐ rest ☐ wraps ☐ walking ☐ stretching

What daily activities are affected due to the problem?

☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs ☐ grooming
☐ housework ☐ laying down ☐ lifting ☐ oral care ☐ sex
☐ going from sitting to standing ☐ shopping ☐ sitting ☐ working ☐ sleeping
☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting ☐ yard work
☐ using technology ☐ transferring ☐ using phone ☐ walking ☐ watching TV

Have you been given a diagnosis for this problem? ☐ yes ☐ no

If yes, what was the diagnosis? _____

What treatment(s) have you tried for your condition?

☐ none ☐ medication ☐ surgery ☐ physical therapy ☐ chiropractic
☐ other: _____

Have you had unexpected weight loss in the last 6 months? ☐ yes ☐ no **If yes, how much?** ____

REVIEW OF SYSTEMS

Musculoskeletal: *Please check all that apply* ☐ none

☐ arm/hand pain ☐ back pain ☐ feet/leg pain ☐ hip ☐ knee ☐ lower back pain
☐ mid back pain ☐ muscle or joint pain ☐ neck pain ☐ redness of joints ☐ stiffness
☐ shoulder(s) pain ☐ swelling of joints ☐ upper back pain

Cardiovascular/Respiratory: *Please check all that apply* ☐ none

☐ chest pain, pressure or discomfort ☐ coughing up blood (hemoptysis) ☐ cold hands/feet
☐ coughing up phlegm ☐ difficulty breathing ☐ dizziness/lightheaded ☐ fainting
☐ irregular heartbeat ☐ palpitations ☐ shortness of breath ☐ wheezing
☐ sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea) ☐ swelling (edema)
☐ tightness in chest ☐ other: _____

REVIEW OF SYSTEMS (continued)

Head/neck: *Please check all that apply* ☐ none

☐ dizziness ☐ facial pain ☐ grinding teeth ☐ headache ☐ hoarseness
☐ jaw clicks ☐ lumps ☐ migraines ☐ sore throat ☐ head injury
☐ stiffness ☐ swollen glands ☐ tooth problems ☐ trouble swallowing ☐ pain
☐ other: _____

Eyes: *Please check all that apply* ☐ none

☐ blurred vision ☐ cataracts ☐ double vision ☐ burning ☐ dryness
☐ flashing lights ☐ glasses/contacts ☐ glaucoma ☐ itching ☐ pain
☐ redness ☐ specks ☐ vision problems ☐ other: _____

Ears: *Please check all that apply* ☐ none

☐ buzzing in ears ☐ decreased hearing ☐ drainage ☐ earache ☐ ear infections
☐ ringing in ears (tinnitus) ☐ poor hearing ☐ poor balance ☐ other: _____

Nose: *Please check all that apply* ☐ none

☐ nose bleeds ☐ discharge ☐ blocked sinuses ☐ allergies ☐ hay fever ☐ itching
☐ excessive mucus ☐ sinus pressure/pain ☐ stuffiness/blockage ☐ other: _____

Throat/Mouth: *Please check all that apply* ☐ none

☐ bleeding ☐ blue lips ☐ braces ☐ dentures ☐ dry mouth
☐ hoarseness ☐ mouth pain ☐ non healing sores ☐ redness ☐ sore throat
☐ swelling ☐ thrush ☐ tooth pain ☐ difficulty swallowing
☐ sores on lips or tongue ☐ other: _____

Urinary: *Please check all that apply* ☐ none

☐ blood in urine (hematuria) ☐ burning or pain ☐ difficulty urinating
☐ frequent urinary tract infections ☐ frequent urination ☐ incontinence
☐ unable to hold urine (incontinence) ☐ kidney stones ☐ kidney infections
☐ up at night to urinate ☐ urgency ☐ water retention ☐ other: _____

Gastrointestinal: *Please check all that apply* ☐ none

☐ change in appetite ☐ change in bowel habits ☐ constipation ☐ diarrhea
☐ swallowing difficulties ☐ yellow eyes or skin (jaundice) ☐ heartburn ☐ nausea
☐ rectal bleeding ☐ other: _____

Endocrine: *Please check all that apply* ☐ none

☐ change in appetite ☐ cold intolerance ☐ constipation ☐ diarrhea ☐ dry skin
☐ excessive thirst ☐ frequent urination ☐ heat intolerance ☐ sweating

Vascular/Hematologic: *Please check all that apply* ☐ none

☐ calf pain with walking (claudication) ☐ cold hands and feet ☐ ease of bleeding
☐ ease of bruising ☐ leg cramping

REVIEW OF SYSTEMS (continued)

Neurologic: *Please check all that apply* ☐ none

☐ dizziness ☐ easily angered/irritated ☐ fainting ☐ frequent crying ☐ tingling
☐ nervousness ☐ memory confusion ☐ neuralgia ☐ tremors ☐ weakness
☐ numbness ☐ poor concentration ☐ seizures ☐ suicidal thoughts
☐ worry/anxiety ☐ other: _____

Psychiatric: *Please check all that apply* ☐ none

☐ anxiety ☐ depression ☐ memory loss ☐ nervousness ☐ stress ☐ other: _____

EMERGENCY CONTACT

Name: _____

Phone: _____ **Relationship:** _____

PAYMENT POLICY

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand, regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

_____ Date: _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date: _____

Print Name of Patient, Parent, Guardian or Personal Representative