PROHEALTH HOOVER
CHIROPRACTIC & REHAB

2116 ROCKY RIDGE ROAD
HOOVER, AL 35216
205.822.2177

CONFIDENTIAL PATIENT INTAKE FORM

NAME:_____AGE:_____DOB:_____SS#_____

HOME ADDRESS:_____CITY:_____ST:_____ZIP_____

EMPLOYER:_____OCCUPATION:_____E-MAIL_____

HOME TEL: _____PAGER/CELL:_____WORK TEL:_____FAX:_____

PREFERRED METHOD OF CONTACT: □HOME TEL □CELL TEL □WORK TEL □EMAIL

EMERGENCY CONTACT:_____ RELATIONSHIP_____ TEL:_____
MARITAL STATUS: □SINGLE □MARRIED □SIGNIFICANT OTHER □DIVORCED □WIDOWED # CHILDREN____
RACE: □AMERICAN INDIAN OR ALASKA NATIVE □ASIAN □BLACK OR AFRICAN AMERICAN
□NATIVE OR OTHER PACIFIC ISLANDER □WHITE □PATIENT DECLINED TO PROVIDE
ETHNICITY: □HISPANIC OR LATINO □NOT HISPANIC OR LATINO □PATIENT DECLINED TO PROVIDE
PRIMARY CARE PHYSICIAN:_____ PHYSICIAN PHONE: _____

REFERRED BY: DR._____ PATIENT: _____ OTHER_____

YOU ARE *CURRENTLY* EXPERIENCING: □BACK PAIN □NECK PAIN □HEADACHE □OTHER_____
DESCRIBE□:_____
THIS HAPPENED *WHEN?* _____ *WHERE?* □HOME □WORK □CAR WRECK □OTHER_____

THIS HAPPENED *HOW?* _____

HAVE YOU HAD THIS OR SIMILAR HAPPEN BEFORE? _____

WHAT MAKES THE PROBLEM BETTER?_____

WHAT MAKE THE PROBLEM WORSE? □SITTING □STANDING □LYING □MOVEMENT □REST
□USE □WALKING □RUNNING □WORKING □ACTIVITY
□BENDING □LIFTING □TWISTING □OTHER_____
DESCRIBE THE PAIN OR SENSATION: □ACHY □BURNING □DULL □NUMB □SHARP
□SHOOTING □SORE □STABBING □STIFF □TINGLING

DOES THE PAIN RADIATE TO ANOTHER AREA OF THE BODY? □NO □YES - *WHERE*? _____

HOW FREQUENT IS THE PROBLEM? □CONSTANT □FREQUENT □INTERMITTENT □OCCASIONAL □ON/OFF
□EVENING ONLY □MORNING ONLY □WORSE IN THE: □AM or □PM

WHAT % OF THE DAY DO YOU EXPERIENCE THIS PROBLEM? □0-25% □26-50% □51-75% □76-100%

OTHER DR.S SEEN FOR THIS CONDITION: □ NO □YES:_____WHEN? _____

PAST CHIROPRACTIC CARE: □NO □YES DRS NAME: _____WHEN? _____

PATIENT SIGNATURE: _____ DATE_____
GUARDIAN SIGNATURE: _____ DATE_____rev.03.27.2014

REVIEW OF SYSTEMS AND HISTORY

Check or circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

P = patient M = mother,
F = father S = Sibling

- □ Heart Disease P M F S
- □ Asthma P M F S
- □ Cancer P M F S
- □ Arthritis P M F S
- □ Headaches P M F S
- □ Diabetes P M F S
- □ MVP P M F S
- □ Emphysema P M F S
- □ Anemia P M F S
- □ Fibromyalgia P M F S
- □ Hernia P M F S
- □ High BP P M F S
- □ Low BP P M F S
- □ Alzheimers P M F S
- □ Alcoholism P M F S
- □ Colitis P M F S
- □ Epilepsy P M F S
- □ Goiter P M F S
- □ Gout P M F S
- □ High Cholesterol P M F S
- □ Kidney Disease P M F S
- □ Leukemia P M F S
- □ Lupus P M F S
- □ Mental Condition P M F S
- □ Obesity P M F S
- □ Rheumatoid Arth. P M F S
- □ Ulcers P M F S
- □ Injuries P M F S
- □ Trauma auto/etc. P M F S
- □ Other_____ _____P M F S

Surgical History

- □ Appendectomy □ Hemorrhoid
- □ Gall Bladder □ Tonsillectomy
- □ Thyroidectomy □ Kidney Stone
- □ Bladder □ Endoscopy
- □ Angioplasty □ Heart Bypass
- □ Back Surgery □Neck Surgery
- □ Arthroscopic_____
- □ Joint Replacement_____
- □ Mastectomy □ Breast Implants
- □ Tubaligation □ C-Section
- □ Endometriosis □ Hysterectomy
- □ Other_____
- □ Other_____

Social History

Caffeine: □ No □ Light □ Heavy
Tobacco: □ No □ Yes
Packs Per day_____
Alcohol: □ No □ Yes
_____per day/week

Work History

- □ No work □ Part time
- □ Full Time □ School
- □ Retired □ Disability

Exercise

- □ Frequently
- □ Occasionally
- □ Rarely/Never

Review Of Systems

Please circle if you have had any problems in any of the following:
(P=Past, 1=Mild, 2=Moderate, 3=Severe)

General Health

P 1 2 3 Fatigue/Tiredness
P 1 2 3 Fever/Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation/Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/Tension/Stress

EENT

P 1 2 3 Vision/Eye
P 1 2 3 Hearing/Ear
P 1 2 3 Throat/Swallowing
P 1 2 3 Nasal/Sinus
P 1 2 3 Headaches/Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/Edema
P 1 2 3 Chest Pain

GI

P 1 2 3 Stomach/Abdominal
P 1 2 3 Diarrhea/Constipation
P 1 2 3 Vomiting

GU

P 1 2 3 Urinary Frequency/Urgency
P 1 2 3 Urinary/Burning/Discoloration
P 1 2 3 Sexual/Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____
□ Fracture_____

NeuroMuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/Tingling
P 1 2 3 Tremors/Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing out

Females

Pregnant: □Yes □No □I Don=t Know
□ Last Menstrual Cycle_____

Males

□ Prostate problems

Present Medication

□None □List_____
_____
_____
_____
_____

Allergies

- □ Penicillin □ Codeine
- □ Aspirin □ Sulfa
- □ Other_____
- □ Other_____

Patient Signature_____Date_____
Reviewer_____Date_____

ProHealth Hoover
Chiropractic & Rehab

PAIN DRAWING

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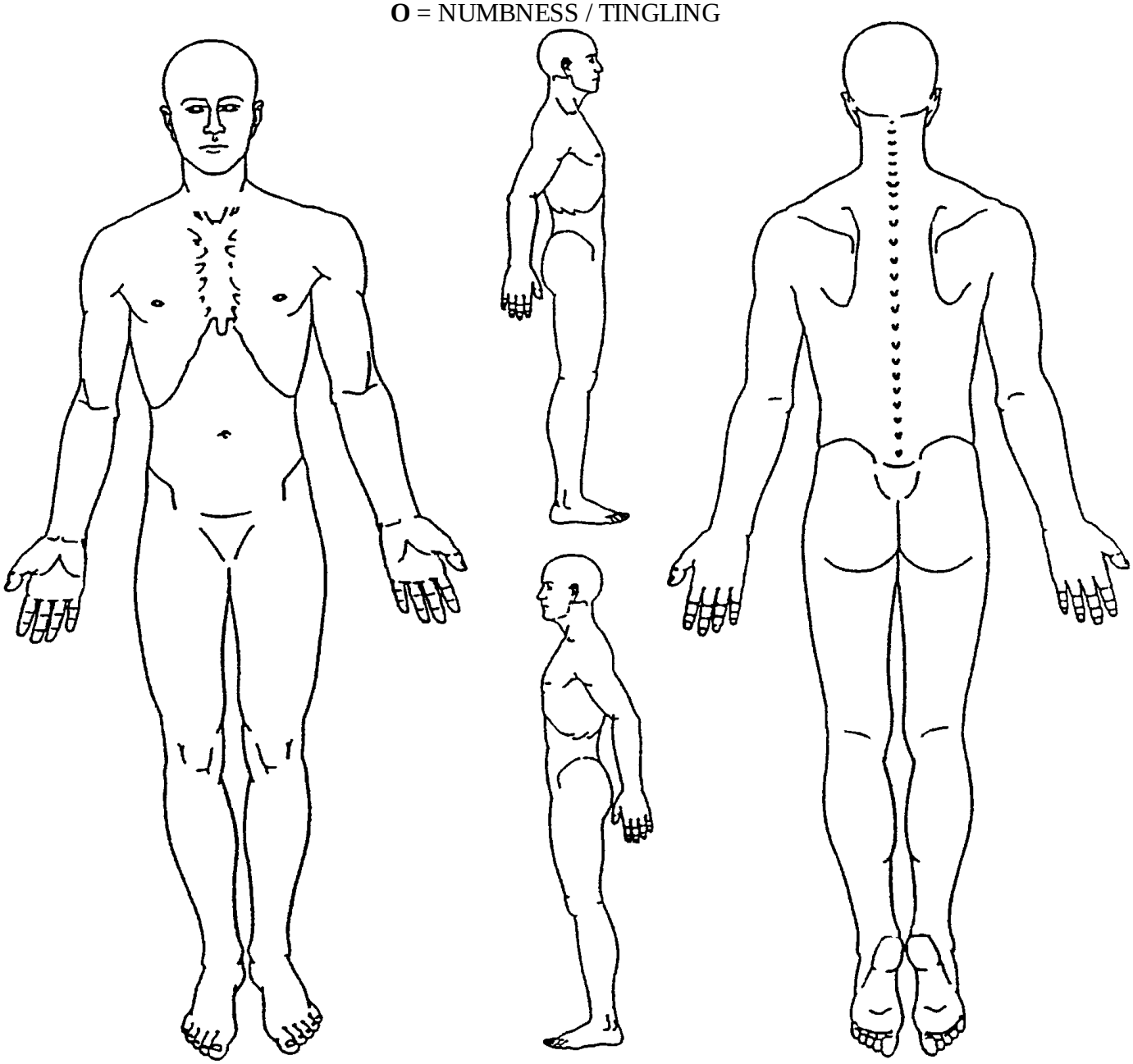
On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature:_____ Date:_____