Case # _____

# BRANDON CHIROPRACTIC: DR. JAY STARK: INTAKE AND HISTORY FORM

## PATIENT INFORMATION

Legal Full Name (Last, First) _____ Middle Initial _____

*Your name has to match what is on your insurance card, in order to be billed out.

Address _____City _____State _____ Zip _____

Phone _____ Would you like text reminders? YES NO

Date of Birth _____ Age _____ Sex ❑ M ❑ F

❑ Married ❑ Single ❑ Widowed ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/ School _____ Occupation _____

Spouse's Name _____ Who is your Primary Care Physician_____

Whom may we thank for referring you? _____

## IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone Number _____

## INSURANCE INFORMATION

Primary Insurance Policy _____ Who is the Policy Holder _____
Relationship to patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Secondary Insurance Policy YES NO (If Yes): Insurance Policy _____
Who is the Policy Holder _____
Relationship to patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____

I understand and agree that I am financially responsible for all charges whether or not paid by my insurance, including my insurance deductible, copayment, and any services rejected by my insurance company or another entity responsible for payment. I authorize the use of my signature on all insurance submissions. Dr. Stark may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payable for related services. This consent does not have any expiration date.

Print Name _____ Date _____

Signature _____ Relation to Patient _____

Name _____ Case #_____

## HEALTH HISTORY

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other _____

Name of other doctors who have treated you for this condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test_____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Have you ever had any of the following? Check what applies

❑ AIDS/HIV
❑ Alcoholism
❑ Allergy shots
❑ Anemia
❑ Anorexia/Bulimia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Arterial Fibrillation
❑ Bleeding Disorders
❑ Breast Lump
❑ Coronary Artery Disease
❑ Cancer
❑ Cardiac arrest
❑ Cataracts
❑ Chemical Dependency
❑ Congestive Heart Failure
❑ Diabetes
❑ Depression
❑ Emphysema
❑ Epilepsy
❑ Fibromyalgia
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Hepatitis
❑ Hernia
❑ Herniated Disk
❑ High Blood Pressure
❑ High Cholesterol
❑ Insomnia
❑ Irritable Bowel Syndrome
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Menopause
❑ Migraines Headaches
❑ Miscarriage
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Neurosurgery
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's Disease
❑ Pinched Nerve
❑ Pneumonia
❑ Polio
❑ Prostate Problems
❑ Prosthesis
❑ Psychiatric Care
❑ Pulmonary Embolism
❑ Rheumatoid Arthritis
❑ Scarlet Fever
❑ Sexually Transmitted Disease
❑ Shortness of Breath
❑ Stroke
❑ Suicide Attempt
❑ Thyroid Problems
❑ Tuberculosis
❑ Tumors, Growths
❑ Ulcers
❑ Vaginal Infections
❑ Vertigo
❑ Whooping Cough
❑ Other _____
_____

**EXERCISE**
❑ None
❑ Moderate
❑ Daily
❑ Heavy

**WORK ACTIVITY**
❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

**HABITS**
❑ Smoking Packs/Day_____
❑ Alcohol Drinks/Week_____
❑ Coffee/Caffeine Cups/Day_____
❑ High Stress Level Reason_____

Are you currently pregnant ❑ No ❑ Yes Due Date _____

Injuries/Surgeries you have had:

When/Date

Falls _____ _____
Head Injuries _____ _____
Broken Bones _____ _____
Dislocations _____ _____
Surgeries _____ _____

| MEDICATIONS | VITAMINS | ALLERGIES |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Name _____ Case # _____

**PATIENT CONDITION**

Reason for Visit _____

When did your symptoms appear? _____ How often have you had this pain? _____

Is it ❑ Constant ❑ Comes and goes Interfere with ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

**Current severity of pain**

Circle: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

**Duration of Pain**
___1 Day
___several days
___1 week
___several weeks
___1 month
___several months
___1 year
___several years

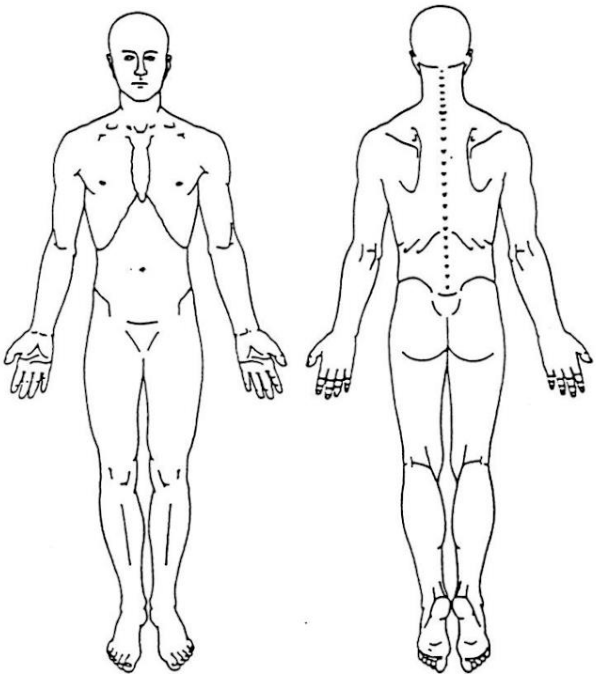
**Timing**
___at night
___constantly
___frequently
___intermittently
___occasionally

**Quality**
___achy
___burning
___dull
___numb
___sharp
___shooting
___stiffness
___stinging
___throbbing
___tingling
___radiating

**Worse with**
___bending forward
___exercise
___lifting
___looking down
___looking up
___nothing
___pulling
___pushing
___repetitive movements
___sitting
___sitting to standing
___standing
___sneezing
___turning the head right
___turning the head left
___twisting
___walking

**Improves with**
___cold
___having adjustments
___heat
___nothing
___reclining
___resting
___sitting
___standing
___sleeping
___stretching
___walking

**Place an X on areas that hurt:**



***DOCTOR'S NOTES:***