CROSSROADS
CHIROPRACTIC

6000 Meadowbrook Mall Ct 3A Clemmons NC 27012

INTAKE PAPERWORK Date:_____ Who referred you to our clinic? _____

Patient Demographics

Name:_____Birth Date:_____-_____-_____Age:_____ ☐ Male ☐ Female

Address:_____City:_____ State: _____ Zip:_____

Email:_____Home Phone:_____Mobile Phone:_____

☐ I authorize my email and phone to be added to Crossroads Chiropractic database for email, text alerts and product promotion

Marital Status: ☐ Single ☐ Married Do you have insurance? ☐ Yes ☐ No

Employeer:_____ Occupation:_____

Spouse Name:_____ Spouse Employeer:_____

Number of children and ages: _____

Emergency Contact Name:_____Relationship:_____Phone Number:_____

HISTORY OF COMPLAINT

1. What would you like to achieve with care in our office? _____

2. Please list the condition(s) or health concerns you have :Primary:_____

Secondary:_____Third:_____Fourth:_____

3. How are these conditions affecting your life? _____

4. When did the problem(s) begin?_____. When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-Day

5. How long does it last? ☐ constant ☐ on and off during the day ☐ It comes and goes throughout the week

6. Is your problem the result of ANY type of accident? ☐ Yes ☐ No

If yes, please explain: _____

_____

7. Have you been treated for this condition by another Chiropractor? ☐ Yes ☐ No

Name of Chiropractor:_____

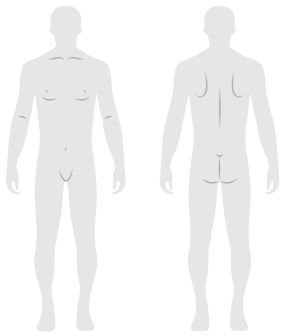
Results: _____

Have you been treated for this condition by any other healthcare provider?

Name and specialty:_____

Results: _____

* **PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:
R =Radiating **B**=Burning **D**=Dull **A** =Aching **N**=Numbness **S** =Sharp/Stabbing **T**=Tingling



What relieves your symptoms?_____

What makes them worse? _____

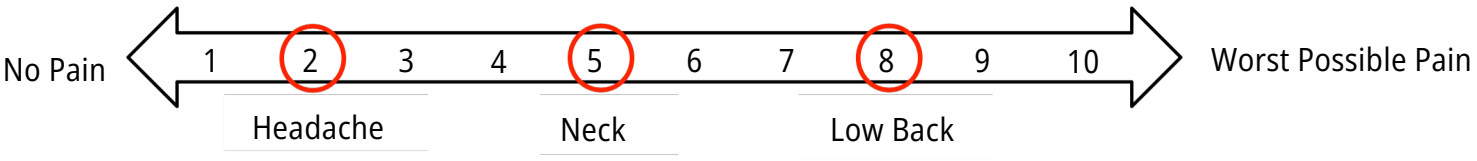
Identify any other injury(s) to your spine, major or minor, that the doctors should know about:

_____

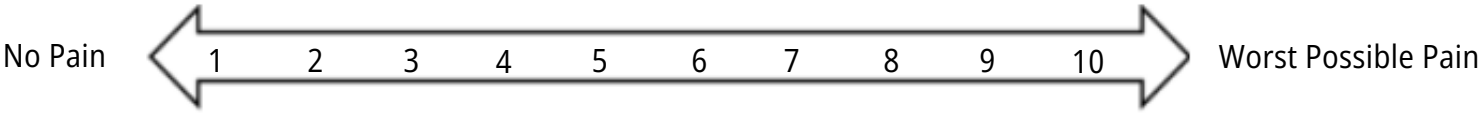
INTENSITY RATING

Please rate your pain: RIGHT NOW, ON AN AVERAGE DAY, WHEN IT"S NOT THAT BAD, AND WHEN IT IS WORST. If you have multiple conditions, please label as shown below.

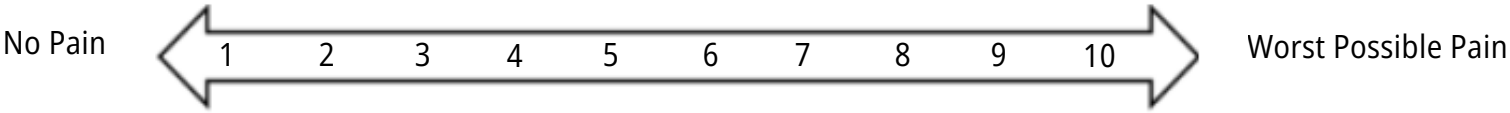
Example



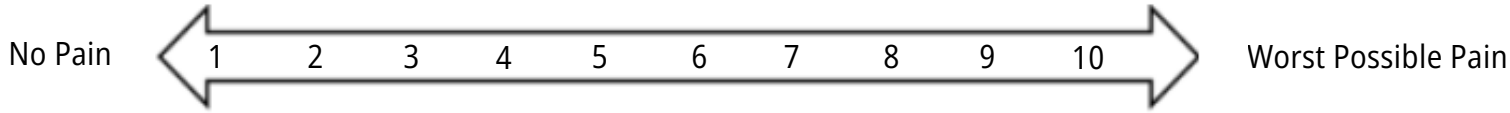
1. What is your pain RIGHT NOW?



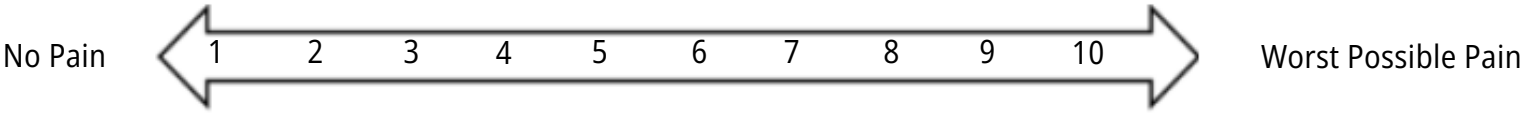
2.What is your TYPICAL or AVERAGE pain?



3. What is your pain level AT ITS BEST (How close to "no pain" are you when you have least amount of pain)?



4.What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



LIST PRESCRIPTION DRUGS YOU TAKE:

_____
_____
_____

LIST ALL SUPPLEMENTS/VITAMINS YOU TAKE:

_____
_____
_____

PAST HISTORY:

1. Have you suffered with a similar problem in the past? ☐ Yes ☐ No If Yes:

How many times? _____ When was the last episode?_____ How did the injury happen?_____

2. Other forms of treatment tried? ☐ Yes ☐ No If yes, please state the type of treatment :_____ Provided by: _____

How long ago? _____ Were the results: ☐ Favorable ☐ Unfavorable Please explain:_____

ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Washing/Bathing/Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
SexualActivities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
YardWork	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	

Please mark **P** for in the Past, **C** for Current, Leave Blank for Never

___Headache
___NeckPain
___JawPain, TMJ
___ShoulderPain
___Upper Back Pain
___Mid Back Pain
___Low Back Pain
___Hip Pain
___Back Curvature
___Scoliosis
___Numb/Tingling arms, hands, fingers
___Numb/Tingling legs, feet, toes
___BrokenBone
___Dislocation

___Pregnant(Now)
___FrequentColds/Flu
___Convulsions/Epilepsy
___Tremors
___Chest Pain
___Pain w/ Cough/Sneeze
___Foot or Knee Problems
___Sinus/Drainage Problem
___Swollen/Painful Joints
___Diabetes
___Skin Problems
___Mood Changes

___Dizziness
___Loss of Balance
___Fainting
___Double Vision
___Blurred Vision
___Ringing in Ears
___Hearing Loss
___Depression
___Irritable
___ADD/ADHD
___Allergies
___Tumors
___Heart Attack
___Fracture

___Prostate Problems
___Impotence/Sexual Dysfun.
___Digestive Problems
___Colon Trouble
___Diarrhea/Constipation
___Menopausal Problems
___Menstrual Problem
___PMS
___Bed Wetting
___Learning Disability
___Eating Disorder
___Trouble Sleeping
___Rheumatoid Arthritis
___Osteo Arthritis

___Ulcers
___Heartburn
___HeartProblem
___HighBloodPressure
___LowBloodPressure
___Asthma
___DifficultyBreathing
___LungProblems
___KidneyTrouble
___GallBladderTrouble
___LiverTrouble
___Hepatitis (A,B,C)
___Disability
___Cancer

PAST HISTORY RELATED TO CURRENT CONDITION

Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	WHAT	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES				
SURGERIES				
DISEASES				

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition? ☐ Yes ☐ No

If yes, whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ Yes ☐ No

2. Are there any hereditary conditions the doctor should be aware of? ☐ No ☐ Yes:_____

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: Consumption occurs how often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug Use occurs how often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies-Recreational Activities: Exercise ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

5 Health Essentials Profile

1. Have you tested with high triglycerides or high cholesterol? (Y / N) Values?_____

2. Have you tested with high blood pressure? (Y / N)

3. Are you diabetic ?(Y / N) Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

4. Do you eat breakfast daily from Monday to Friday? (Y / N)

5. How many days per week do you skip one meal? (0) (1) (2) (3) (4 +)

6. How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4 -6) (7 +)

7. How many servings of fruit do you have a day? (0-1) (2-3) (4 +) How many servings of vegetables do you have a day? (0-1) (2-3) (4 +)

8. Do you regularly drink sodas (1or more everyday)? (Y / N)

9. Current weight?_____ Target weight?_____

10. Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

11. Have you ever noticed mold growing or smell mildew in your home or your place of work? (Y / N)

12. Have you received a full standard profile of vaccinations? (Y / N)

13. Do you receive yearly flu shots? (Y / N). How many flu shots have you received? _____ (estimate)

14. Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal) ?(Y / N)

15. Do you average less than 7 hours of sleep per night (Y / N)

16. Do you ever take pills to go to sleep or relax (Y / N)

How willing are you to change any of these things to reach your health goals? (Scale of 1-10)_____

I hereby authorize payment to be made directly to Crossroads Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Crossroads Chiropractic for any and all services I receive at this office.

_____ _____ / _____ / _____

Patient or Authorized Person's Signature Date Completed

_____ _____ / _____ / _____

Dr. Jason Barker | Dr. Andrew Green Date Form Reviewed