Ewer Specific Chiropractic & NEUROLOGY

Ewer Specific Chiro & Neurology
298 Old Route 30
Greensburg, PA 15601

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Personal Information

*First Name: _____
Middle Name: _____
*Last Name: _____
*Gender: ○ Female ○ Male
*Date of Birth: _____
Social Security #: ___ ___ ____
Height: [ ] Feet [ ] Inches
Weight: _____
Marital Status: [ ]
Spouse's Name: _____
Number of Children: [ ]

Emergency Contact: _____
Relationship: _____
Phone: _____

Contact Information

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

*Home Phone: _____
Cell Phone: _____
Work Phone: _____

Country: United States
Address Line 1: _____
Address Line 2: _____
City: _____
State/Province/Region: [ ]
*Zip/Postal Code: _____

Current Symptoms

Where did the injury occur?

○ Automobile ○ Work ○ 3rd Party Premises ○ Other

Date of Injury: _____

Please Describe how the injury, pain, or discomfort originated:

Please describe your pain/discomfort:

Select frequency you experience pain from this condition:

○ Always ○ Hourly ○ Daily ○ Occasionally

Does this condition interfere with any of your daily activities or routines?

○ No ○ Yes

Has this condition affected your quality of sleep or ability to sleep?

○ No ○ Yes

Has this condition affected your appetite?

○ No ○ Yes

If Yes, Explain:

Have you missed any work due to this injury?

○ No ○ Yes

If yes:
Select unable to work from date:
Select day you have or will return to work:

Have you reduced or limited your work hours because of this condition?

○ No ○ Yes

If Yes, Explain:

Is the pain/discomfort worse at certain times of the day?

○ No ○ Yes

If Yes, Explain:

Does the weather affect your pain/discomfort?

○ No ○ Yes

If Yes, Explain:

List anything that aggravates your condition:

List anything that relieves or improves your condition:

Have you received professional treatment for this condition?

No Yes

If Yes, Explain:

Have you had X-rays taken for this condition?

No Yes

If Yes, Where?

Pain level Rating - Scale 1 to 10 (Where 1 is least pain and 10 is maximum pain)

At its best: At its Worst:

Current Level:

Have you ever had this same condition?

No Yes

If Yes, When?:

List other practitioners seen for this injury/condition:

Personal Health History

Family/Primary Physician

Date of Last Physical Exam:

Name of Family Physician or Physician Seen:

Physician Phone:

Physician City:

Physician State:

Physician Zip:

Please list any health conditions that you have been treated for in the last year:
(condition, cause, current/resolved)

Separate details with "," comma as shown above.

Have you had previous chiropractic care?

No Yes

Condition(s) treated:

Date of last chiropractic visit:

Are you pregnant, or have you had any signs of pregnancy? (Female Only)

No Yes

Are you planning to get pregnant in the next 12 months? (Female Only)

No Yes

List current medications:
(name, amounts, frequency, length of use, reason for use)

Separate details with "," comma as shown above.

List current vitamins, minerals, supplements, or herbs:
(name, amounts, frequency, length of use, reason for use)

Separate details with "," comma as shown above.

Family Health History

Please list diagnosed health conditions and untimely deaths.(condition, relationship to you)
(Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)

Separate details with "," comma as shown above.

(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Social History & Life Choices:

Alcohol
○ Daily ○ Weekly ○ Occasionally ○ Never

Caffeine Drinks & Products
○ Daily ○ Weekly ○ Occasionally ○ Never

Diet Food Products
○ Daily ○ Weekly ○ Occasionally ○ Never

Drugs
○ Daily ○ Weekly ○ Occasionally ○ Never

Energy Products or Over-the-Counter Stimulants
○ Daily ○ Weekly ○ Occasionally ○ Never

Exercise
○ Daily ○ Weekly ○ Occasionally ○ Never

Fresh & Homemade Foods
○ Daily ○ Weekly ○ Occasionally ○ Never

Preprocessed, Packaged, & Restaurant Food
○ Daily ○ Weekly ○ Occasionally ○ Never

Soft Drinks
○ Daily ○ Weekly ○ Occasionally ○ Never

Tobacco
○ Daily ○ Weekly ○ Occasionally ○ Never

Water
○ Daily ○ Weekly ○ Occasionally ○ Never

Health Problems & Concerns:

Please select all that you have had or currently have.

- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cataracts
- ☐ Chest Pain
- ☐ CHF (congestive heart disease)
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Gallbladder disease/stones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Menstrual Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Liver disease/cirrhosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Retinal Disease
- ☐ Sciatica
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep Problems/Insomnia
- ☐ Skin Sensitivity
- ☐ Smoked
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition

- ☐ COPD/emphysema
- ☐ Cramps
- ☐ CVA (stroke/TIA)
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Diagnosed emotional/mental disorders
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lung disease
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Nosebleeds
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other

Other:

Have you had any of these Cardiovascular Diseases? Please select all that apply.

☐ Myocardial infarction ☐ Hypertension ☐ Hypercholesterolemia ☐ Bypass surgery
☐ Coronary artery disease

Do you have Diabetes? If so what type?

○ Type I ○ Type II ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

☐ Ulcers ☐ Reflux ☐ IBS

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. If text reminders have been set up, I authorize this office to text me a one-time customer feedback questionnaire that would appear on Google Review.

* ☐ **I agree with this statement of authorization**

Name of the Insured:
(Please Print) _____

Patient's/Guardian's signature: _____ **Date:** _____

Signature

Clear Signature