TAPROOT
CHIROPRACTIC & WELLNESS

New Patient Intake Form

Name: _____ Date: _____/_____/_____

Preferred Name: _____ DOB: _____ Gender: _____

Address: _____

City, State, Zip: _____

Email: _____

Cell #: _____ Home #: _____

Do you want e-mail or text appointment reminders? **Email / Text / None**

Marital Status: M / S / W / D Name of Spouse: _____

Do you have children? Y / N How many: _____ Ages: _____

Names: _____

Who would you like to have access to your records?
(in Texas, spouses cannot have access to records without consent or power of attorney)

_____

If you would like us to update your MD, OB, DO, PT, or Midwife about your care, please provide their name and number:

_____

Who can we thank for referring you? _____

Do you have Medicare? Y / N
If yes, this clinic is a Non-Participating Medicare Provider. Please see the front desk staff.

Name: _____ Date: _____/_____/_____

Lifestyle Questions:

What kind of care are you in need of? (circle one)

Wellness Care **Pain/Symptom Relief** **Pain Relief Followed by Wellness Care**

Are there any specific therapies/services you are interested in? _____

Dry Needling/Cupping/Soft Tissue Work Laser/LightForce Class IV Laser PEMF (Pulse)

Infrared Sauna Decompression Ultrasound Active Rehab

Torque Release Technique (TRT) McTimoney Method

Have you ever been under chiropractic care in the past? Y /N

If Yes, when was your last adjustment? _____ How was your experience? _____

What is your level of commitment to yourself, your life, and your Well-Being? High / Medium / Low

How is your diet: Good / Fair / Poor Are you seeking any help with nutritional counseling? Y/N

Are you on a specific type of diet? _____

What is your daily fluid intake? _____ How many hours do you sleep per night? _____

Do you exercise? What do you do and how often? _____

What are your play and relaxation activities? _____

What type of work do you do? _____ Do you enjoy it? _____

Familial History--circle all that apply:

Key: M=mother, F=father, S=self, O=other

Stroke: M / F / S / O : _____

Cancer: M / F / S / O : _____

Diabetes: M / F / S / O : _____

High Blood Pressure: M / F / S / O : _____

Heart Disease: M / F / S / O : _____

Other Serious Illnesses:_____

Past History of Surgery:

Date _____ Procedure:_____

Outcome:_____

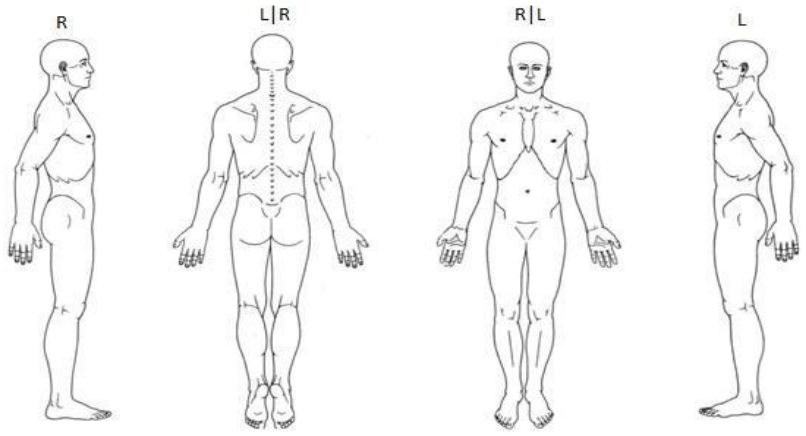
Date: _____ Procedure:_____

Outcome:_____

Name: _____ Date: _____/_____/_____

History of Current Complaints

Please circle and number your complaint area/s of the body on the diagram below:



Complaint #1: _____

When did this first begin? _____ Is this the first time this has happened? **Y / N**

Did you have an accident/injury? **Y / N** if yes, describe: _____

Anything that makes this feel better? _____

Anything that makes this feel worse? _____

Have you seen any other doctors for this condition? **Y / N** did they take x-rays or an MRI? **Y / N**

On a scale of 1-10 how is your pain right now? _____ At its worst? _____ At it's best? _____

Describe the frequency of your pain: **Constant Frequent Intermittent Occasional**

What does it feel like (aching, burning, dull, sharp, tight, numb, etc.)? _____

Complaint #2: _____

When did this first begin? _____ Is this the first time this has happened? **Y / N**

Did you have an accident/injury? **Y / N** if yes, describe: _____

Anything that makes this feel better? _____

Anything that makes this feel worse? _____

Have you seen any other doctors for this condition? **Y / N** did they take x-rays or an MRI? **Y / N**

On a scale of 1-10 how is your pain right now? _____ At its worst? _____ At it's best? _____

Describe the frequency of your pain: **Constant Frequent Intermittent Occasional**

What does it feel like (aching, burning, dull, sharp, tight, numb, etc.)? _____

Name: _____ Date: _____/_____/_____

If you have other complaints/concerns, please describe below:

_____

_____

_____

_____

_____

_____

Stress Survey

Key: P=Past issue C=Current issue N=Never an issue

Physical Stress:	Choices:	Please explain:
Birth Traumas (as mother or a child)	P C N	
Slip/Falls	P C N	
Car Accidents	P C N	
Sports Injuries	P C N	
Physical Abuse	P C N	
Work Injuries	P C N	
Poor Posture	P C N	
Sitting on your wallet for years	P C N	
Sleeping Position i.e. stomach/side	P C N	
Extensive Computer Work	P C N	
Carrying Heavy Purse/Book bag/Child	P C N	
Repetitive Lifting/Bending	P C N	
Driving for Many Hours	P C N	
Continuous Hours Standing/Sitting	P C N	
Bone Fracture/Surgery	P C N	
Headaches/Migraines	P C N	
Neck Pain	P C N	

Name: _____ Date: _____/_____/_____

Mid-Back Pain	P C N	
Extremity Pain	P C N	
Low Back Pain	P C N	
Pregnancy	P C N	

Although physical stress is the reason most people seek chiropractic care, emotional and chemical stresses can affect your body's healing ability. Knowing the extent of these stresses can better help the doctor determine your prognosis.

Emotional Stress:

Relationships	P C N	
Career	P C N	
Children	P C N	
Money	P C N	
Fast Paced Life	P C N	
Hold in Feelings	P C N	
Quick Tempered	P C N	
Verbal Abuse	P C N	
Perfectionist	P C N	
Sickness or Loss of Loved One	P C N	

Chemical Stress:

Environment i.e. pollution	P C N	
Smoker/Vape/Nicotine Amount	P C N	
Second Hand Smoke	P C N	
Poor Diet	P C N	
Caffeine/Amount	P C N	
Artificial Sweeteners	P C N	
Over the Counter Drugs (i.e. Advil, Tylenol, Aspirin)	P C N	
Recreational Drugs	P C N	
Alcohol intake	P C N	# of drinks/wk:

Name: _____ Date: _____/_____/_____

Anything additional that you would like the doctor to know?

_____

_____

_____

Please List all Prescription drugs and vitamins/supplements:

_____

_____

_____

Patient Signature: _____ Date: _____

If patient is a minor, parent/guardian name (please print): _____