CHIROPRACTIC INTAKE FORM
Dr. Jenny T Proutsos, BKin(Hons), D. Acu., DC

PATIENT INFORMATION
Name: _____Sex (please circle): Male Female
Date of Birth: mm/dd/yyyy ____/____/_____ Age:_____
Address: _____City: _____Postal Code:_____
Phone:(Home)_____(Cell)_____
May we leave you a message at either number? (please circle) YES NO
How did you find out about us?
_____
Occupation: _____Marital Status:_____
Emergency Contact: (Name) _____(Relationship) _____ (Phone number)
_____

Fee Schedule
Initial Assessment: $100 Subsequent visit: $45 Extended visit: $65
Re-Assessment: $60 Acupuncture: $45

Cancellation Policy:
24 hours notice if you are unable to make your scheduled appointment. Routinely missed appointments without advanced notice will be billed at the regular fee.

A deposit is required prior to ordering custom-made orthotics.

I have read and understand the financial policy. I agree to pay any and all charges incurred for services rendered and/or items purchased to Dr. Jenny T Proutsos.

Patient Signature: _____Date: _____
Patient Name (Print): _____

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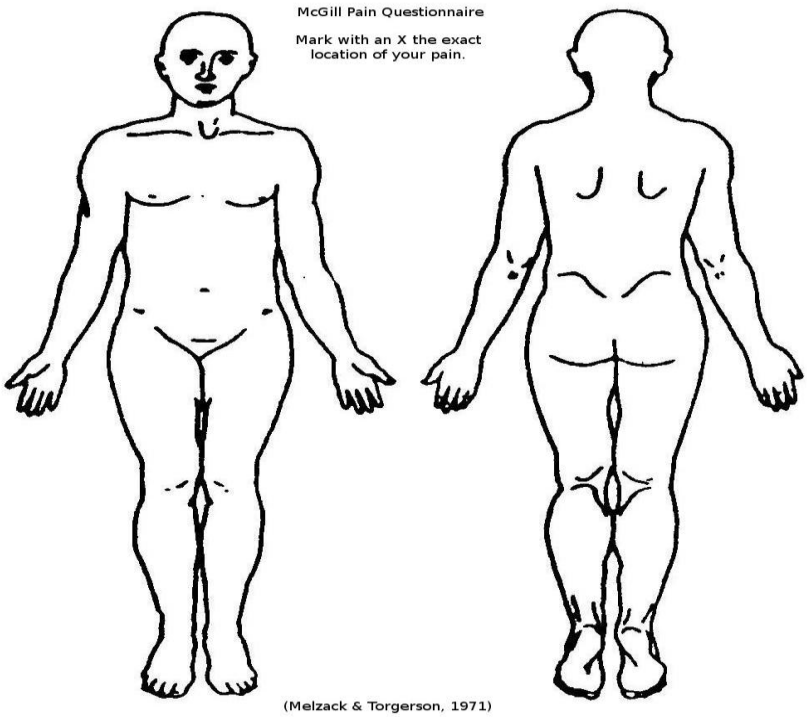
PATIENT HEALTH QUESTIONNAIRE

Patient name: _____
Date:_____

1. What are you being seen for today?:_____

When did your symptoms begin?:_____

Please indicate the area on the provided diagram which best represents the pain(s) and or sensation(s) you are currently experiencing.



2. How often do you experience your symptoms?

☐ Constantly (76-100% OF THE DAY)

☐ Frequently (51-75% OF THE DAY)

☐ Occasionally (26-50% OF THE DAY)

☐ Intermittently (0-25% OF THE DAY)

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Date:_____

3. What describes the nature of your symptoms?

☐ Sharp

☐ Shooting

☐ Dull ache

☐ Burning

☐ Numb

☐ Tingling

4. How are your symptoms changing?

☐ Getting better

☐ Not changing

☐ Getting worse

☐ UNBEARABLE

5. Describe your symptoms at their:

A. Worst: 0 1 2 3 4 5 6 7 8 9 10

B. Best: 0 1 2 3 4 5 6 7 8 9 10

6. Activities that make symptoms worse:_____

7. Activities that make symptoms better:_____

8. Who have you seen for your symptoms?

☐ No one

☐ Medical doctor

☐ Chiropractor

☐ Physical therapist

☐ Other _____
When and what treatment?_____

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Patient name: _____
Date:_____

9. Have you had similar symptoms in the past?
□ YES
□ NO

If yes, who did you see?
□ Medical doctor
□ Chiropractor
□ Physical therapist
□ Other _____

For each condition listed below, please circle which conditions you presently have. For conditions you have experienced in the past please place an “x” beside the condition.

Headache	High blood pressure	Diabetes	Neck pain
Heart attack	Excessive thirst	Upper back pain	Chest pain
Frequent urination	Mid back pain	Stroke	Low back pain
Angina	Systemic lupus	Epilepisy	Shoulder pain
Kidney stones	Depression	Upper arm pain	Kidney disorders
Osteoporosis	Jaw pain	Bladder infection	HIV/AIDS
Hip pain	Painful urination	Knee pain	Loss of bladder control
Joint swelling	Foot pain	Prostate problems	Arthritis
General fatigue	Abdominal pain	Abnormal weight gain/ loss	
Ulcer	Loss of appetite		

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Patient name: _____
Date:_____

List any other health problems:

Hepatitis	Liver/gallbladder disorder		Cancer
Thyroid Females only	Blurred or double vision		Smoking
Birth control pills	Dizziness	Stroke	Pregnancy
Muscle incoordination	Blood clots	Hormone replacement therapy	

INDICATE IF AN IMMEDIATE FAMILY MEMBER (PARENT OR SIBLING) HAS HAD ANY OF THE FOLLOWING:

Rheumatoid Arthritis	Heart problems	Diabetes
Cancer Lupus	Other	

List all prescription and over-the-counter medications and all nutritional/herbal supplements you are taking:
_____
_____

List all surgical procedures you have had and any times of hospitalization:
_____
_____

What is your height and weight?
Height:_____ _____ Feet Inches Weight: _____ LBS.

Do you wear orthotics? ☐ YES ☐ NO

Are you interested in custom made orthotics?

☐ YES ☐ NO

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Patient name: _____

Date:_____

ADDITIONAL COMMENTS

_____

PATIENT SIGNATURE:

_____

DATE:

_____