Dr. Melissa Menges-Smith, D.C.
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# Patient Intake Form

*Please present your driver's license and insurance card(s) so we can put a copy in your file.*

**Date:** ____________________

## PATIENT INFORMATION

**Name:**________________________________________________________________________________
(First) (M.I.) (Last) (Nickname)

**Address:** _____________________________________________________________________________
(Number, Street, Unit #) (City, State) (Zip)

**Birthday:** _____________________ **Age:**________ **Circle:** Male/Female **SSN**:___________________

**Occupation:** _________________________________ **Employer:**_______________________________

Single Married Divorced Widowed Separated **Spouse's Name:** ____________________________

How did you hear about us? ______________________________________________________________

Parent(s) Name (if a minor): ______________________________________________________________

## CONTACT INFORMATION

Home Phone______________________Cell ____________________Work_______________________

Email ________________________________________ Best way to reach you: Home/Cell/Work/Email

## IN CASE OF EMERGENCY CONTACT

Name:______________________________________Relationship: ___________________________

Home Phone______________________Cell ____________________ Work_______________________

## HEALTH HISTORY

Date of Last: Spinal X-Ray _____________MRI_____________CT Scan_____________Other __________

List ALL medications you are taking:________________________________________________________

_____________________________________________________________________________________

List ANY medications you are allergic to: __________________________________________________

List ALL supplements (vitamins/herbs/minerals) you are taking: ________________________________

_____________________________________________________________________________________

**FEMALES:** Are you pregnant or Nursing? YES/NO Date of last menstrual cycle _____________________

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**Patient Condition**

What is your **MAJOR** symptom/problem? ____________________________________________

What is/are your secondary symptom(s)/problem(s)? ____________________________________

When did your symptoms begin? ______________________________

What triggered the onset of symptoms? _______________________________________________
___________________________________________________________________________

Have you had this problem before? Yes/No     Is your condition getting progressively worse? Yes/No

Is this problem: 100% 75% 50% 25% of the day?

How does it feel? Burning Sharp Shooting Dull Aching Stiff Tingling Throbbing Swelling

Other: ______________________________________________________________________

Circle the severity of your pain on a scale of 0 to 10: **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)**

What makes your condition better? ____________________ Worse? _______________________

Does it interfere with your: WORK SLEEP DAILY ROUTINE RECREATION OTHER____________

**What other treatments have you had for this condition?**

Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery Other _________

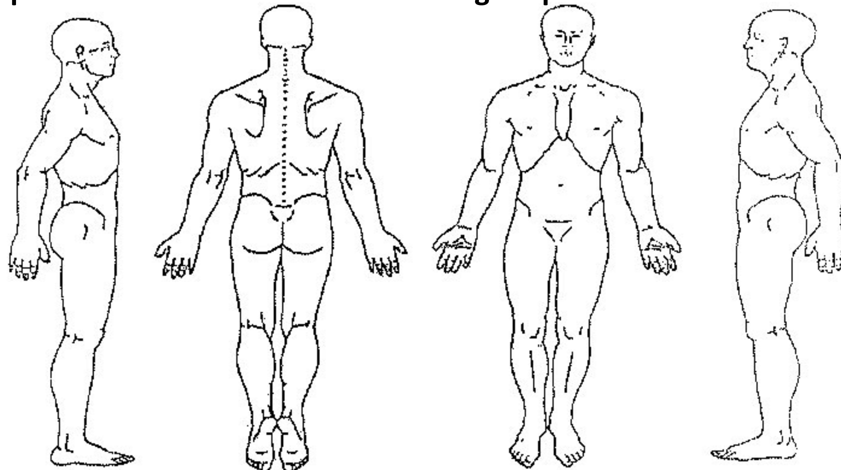
Name of other doctors who have treated you for this condition ______________________________

Describe the other doctor's treatment for your condition ___________________________________

Other symptoms other than major condition_____________________________________________

**Please mark your current symptoms as described below on the figure provided:**

Legend:
X – PAIN
O – ACHE
// - PINS AND NEEDLES
^^ - NUMBNESS



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**Circle any of the following conditions you have had:**

| | | | |
|---|---|---|---|
| AIDS/HIV | Diabetes | High Blood Pressure | Prostate Problems |
| Allergies | Digestion Problems | Insomnia | Rheumatoid Arthritis |
| Anxiety/Depression | Earache | Irregular Cycle | Sciatica |
| Arm/shoulder pain | Ear Ringing | Kidney Problems | Shingles |
| Arthritis | Epilepsy | Leg Pain | Sinus Infection |
| Asthma | Headaches | Low back pain | Stroke |
| Bladder Problems | Migraines | Neck pain | Thyroid Problems |
| Cancer | Heart Disease | Numbness | TMJ |
| Chronic Fatigue | Hemorrhoids | Osteoporosis | Venereal Disease |
| Deafness | Herniated Disk | Poor Circulation | Vertigo/Dizziness |

Indicate your hours and type of exercise: ______________________________

Social Habits: circle Yes or No and provide detailed explanation if applicable

| | | | |
|---|---|---|---|
| Smoking: | No | Yes | If yes, indicate the number of packs per day: ____________ |
| Alcohol: | No | Yes | If yes, indicate the number of drinks per week: ____________ |
| Caffeine: | No | Yes | If yes, indicate the number of cups per day: ____________ |
| Stress: | No | Yes | If yes, indicate the reason and level per day: ____________ |

**Have you had any:** **Description** **Date**

Automobile Accidents: ______________________________

Surgeries: ______________________________

Broken Bones: ______________________________

Falls/Head Injuries: ______________________________

______________________________ ______________
**Printed name of patient** **Date of Birth**

______________________________ ______________
**Signature of patient** **Date**

______________________________ ______________
**Signature of Dr. Melissa Menges-Smith, D.C.** **Date**

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**Review of Systems**

**Check all that apply:**

**General**

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping
- Hair and nail changes
- Other

**Skin**

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Other

**Ears**

- Decreased hearing
- Ringing in ears
- Earache
- Drainage
- Other

**Nose**

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain
- Other

**Eyes**

- Vision
- Glasses or contacts
- Pain
- Redness
- Blurry/double vision
- Flashing lights
- Specks
- Glaucoma
- Cataracts
- Other

**Hematologic**

- Ease of bruising
- East of bleeding
- Other

**Head/Neck**

- Lumps
- Swollen glands
- Pain
- Stiffness
- Hoarseness
- Sore throat
- Trouble swallowing
- Headache
- Head injury
- Other

**Mouth**

- Teeth
- Gums
- Bleeding
- Dentures
- Sore tongue
- Dry mouth
- Thrush
- Non-healing sores
- Other

**Breasts**

- Lumps
- Pain
- Discharge
- Self-exam
- Other

**Respiratory**

- Cough (wet/dry/productive)
- Sputum (color/amount)
- Coughing up blood
- Shortness of breath
- Wheezing
- Painful breathing

**Cardiovascular**

- Chest pain or discomfort
- Tightness
- Palpitations
- Shortness of breath
- Difficulty breathing
- Swelling
- Sudden awakening with shortness of breath
- Other

**Gastrointestinal**

- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea
- Yellow skin/eyes
- Other

**Urinary**

- Frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Other

**Endocrine**

- Heat/cold intolerance
- Sweating
- Frequent urination
- Thirst
- Change in appetite
- Other

**Vascular**

- Calf pain with walking
- Leg cramping
- other

**Musculoskeletal**

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma
- Other

**Neurologic**

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremors
- Other

**Males**

- Pain with sex
- Hernia
- Penile discharge
- Sores
- Masses or pain
- Erectile dysfunction
- STD's
- Other

**Females**

- Pain with sex
- Vaginal dryness
- Hot flashes
- Vaginal discharge
- Itching or rash
- STD's
- other