Intake Form
Congratulations on Getting Started!!!
For your first appointment, please bring the following items:

Any previous blood work, imaging,
lab analyses or medical records.

Your completed paperwork.

Shorts and a tank top
(or loose-fitting and non-restricting clothing)
to be worn during exam.

A spouse, relative or friend to make sure of any of their questions are answered

We ask that you please do not wear eye make-up to your exam as it interferes with our testing equipment.

Your completed paperwork.
Please Note: To secure your examination appointment, please completely fill out this form and provide it to the front desk staff upon arrival for your appointment. If we do not receive your form completely filled out, we may have to reschedule your appointment.

If you are here for a suspected concussion or head injury, please see front desk for additional questionnaire.

1. PATIENT DEMOGRAPHICS
Name:
Gender:
Street Address:
State Zip:
Mobile Phone:
Work Phone:
Email Address:
Date of Birth:
Date:
Age:
Circle One: Married Single Partnered Widowed

2. EMERGENCY CONTACT

Name/Number/Relationship:

3. EMPLOYMENT INFORMATION

Employer Name:

Job Duties:

Occupation

Are you here because you were injured in a:
☐Vehicle Collision ☐Work Related Injury ☐Other ☐None of These

4. HEALTH COMPLAINTS

What is your primary complaint?____

When did the primary complaint start?____

Have your symptoms changed? How?
____

Is the primary complaint: Local ☐ Widespread ☐
Did it come on: Immediately ☐ Rapidly ☐ Gradually ☐

Using the scale below, rate how your primary complaint affects your life (circle only number below).
no pain or discomfort 1
complaint causes slight discomfort 2
complaint that does not affect my activity 3
complaint that rarely affects my daily activities 4
complaint that often affects my daily activities 5
complaint that impedes my daily activities 6
complaint that impedes my work/ school schedule 7
complaint that prevents me from working at all 8
complaint that prevents working and all physical activity 9
complaint that keeps me bedridden 10
complaint that impedes my daily activities 11
complaint that causes thoughts of suicide 12

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CHIROPRACTIC
& WELLNESS

5. LIFESTYLE

List any prescription or over-the-counter medications you are currently taking.
Medications/Supplements / Reason:

____

____

Please list any allergies or
sensitivities____

How many hours of television do you watch every day?

How many hours a day do you use your phone, computer or tablet at work or home?

How many hours a day do you ride in a car or other vehicle?

How often do you exercise? _______________________

What kind of exercise do you prefer?

How many servings of alcohol do you consume weekly?

How many servings of caffeine do you consume weekly?

How many servings of soda do you consume weekly?

How often do you use tobacco products weekly?

Please list all dates of motor vehicle collisions, if any:

Please list any fractures or dislocations:

Please list any and all surgeries, if any:

6. WOMEN ONLY

Are you pregnant? ☐Yes ☐No
Taking Birth Control? ☐Yes ☐No
Date of Last Menstruation? ___/___/___

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7. MEDICAL HISTORY

Mark the following conditions as they currently pertain to you:

Alcoholism
Anemia
Arthritis
Cancer
Epilepsy
AIDS
Chicken Pox
Fibromyalgia
Measles
Pneumonia
STD
Heart Problems
Diabetes
Stroke
Low Back Pain
Head Pain
Neck pain
Blurred vision

Dizziness
Ringing in the ears
Muscle weakness
Difficulty walking
Balance challenges
Brain Fog
Attention deficits
Sleep Apnea
Sinusitis
Trigeminal Neuralgia
Blood clot
Cataracts
Glaucoma
Appendicitis
Eczema
Goiter
Multiple Sclerosis
Rheumatic Fever

Tuberculosis
Irritable Bowel
Bladder Problems
Stomach Problems
Thyroid Disorder
Sleep Disorders
Arteriosclerosis
Emphysema
Gout
Mumps
Rheumatoid Arthritis
Allergies
Asthma
Ulcer
Acid reflux
Breast Lumps
Lyme disease
Pacemaker

Please describe any other medical problems that you have had in the past and present. This will include any surgeries or treatments for injuries or diseases as well as conditions that were not treated. This includes injuries, accidents and falls.

Have you ever been knocked out, had a lapse in memory or injured your head or neck?
☐Yes ☐No.
If yes, Please explain:____

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& WELLNESS

8. FAMILY HISTORY

Please indicate disease and family relationship with you.

Diabetes ____

Depression ____

Heart Disease ____________________________________

Headaches ____

High Blood Pressure _____________________________

Bleeding Disorder _________________________________

High Cholesterol ________________________________

Stroke ____

Cancer ____

Thyroid Disease___________________________________

Kidney Problems ________________________________

Epilepsy ____

9. CURRENT COMPLAINTS

Please check the appropriate box for any of the following symptoms, which you now have or have had previously.

THIS IS A CONFIDENTIAL HEALTH REPORT.

Please add letter next to symptom: Current = C; Past = P.

Cardio-Vascular

Hardening of the Arteries
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Poor Circulation
Rapid Heartbeat
Chest Pain

Respiratory

Chronic Cough
Difficulty Breathing
Wheezing
Spitting up Blood
Spitting up Phlegm

Skin

Bruise Easily
Dryness
Skin Eruptions (rash)
Discolorations
Varicose Veins

Genito-Urinary

Bed-Wetting
Blood in Urine
Frequent Urination
Kidney Infection
Kidney Stones
Painful Urination
Prostate Problems
Pus in Urine

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Nervous System

Numbness / Tingling
Loss of Feeling
Paralysis
Dizziness
Fainting
Headache
Loss of Memory
Muscle Jerking
Loss of Taste / Smell
Cold Feet / Hands
Convulsions
Confusion
Depression
Insomnia

Pain

Head
Neck
Mid back
Low back
Muscle
Hands
Elbow
Shoulders
Hips
Legs
Knees
Feet
Other joints
Eye
Face
Jaw
Any other pain

Other symptoms

Vision Problems
Ear Pain
Ear Noises
Ear Discharge
Hearing Loss
Nose Pain
Nose Bleeds / Discharge
Nasal Obstruction
Sore Mouth
Sore Throat
Hoarseness
Difficult Speech
Sinus Infection
Appetite Changes
Difficulty Chewing
Swallowing
Excessive Thirst
Nausea
Vomiting Blood
Abdominal Pain
Diarrhea
Constipation
Bloody / Black Stool
Hemorrhoids
Liver Problems
Gallbladder Problems
Weight Trouble (Gain or loss)
Muscle Spasm
Walking Problems

For Women Only

Back Ache or Cramps
Excessive Menstrual Flow
Hot Flashes
Irregular Cycle
Menopausal Symptoms
Painful Menstruation
Vaginal Discharge
Vaginal Pain
Breast Pain
Miscarriage

10. SYMPTOM CHECKLIST

For the following symptoms, please select a corresponding number to indicate the severity of your symptoms. If you have a symptom that is not listed, please use the other box and rat it using the following criteria.

0 = None
1 - 2 = Mild
3 - 4 = Moderate
5 - 6 = Severe

Headaches 0 1 2 3 4 5 6
"Pressure in Head" 0 1 2 3 4 5 6
Neck Pain 0 1 2 3 4 5 6
Nausea or Vomiting 0 1 2 3 4 5 6
Dizziness 0 1 2 3 4 5 6
Blurred Vision 0 1 2 3 4 5 6
Balance Problems 0 1 2 3 4 5 6
Sensitivity to Light 0 1 2 3 4 5 6
Sensitivity to Noise 0 1 2 3 4 5 6
Feeling Slowed Down 0 1 2 3 4 5 6
Feeling in a Fog 0 1 2 3 4 5 6
Difficulty Concentrating 0 1 2 3 4 5 6
Difficulty Remembering 0 1 2 3 4 5 6
Fatigue or Low Energy 0 1 2 3 4 5 6
Confusion 0 1 2 3 4 5 6
Drowsiness 0 1 2 3 4 5 6
Trouble Falling Asleep 0 1 2 3 4 5 6
More Emotional 0 1 2 3 4 5 6
Irritable 0 1 2 3 4 5 6
Sadness 0 1 2 3 4 5 6
Nervous or Anxious 0 1 2 3 4 5 6

Does mental activity increase your symptoms?

Does physical activity increase your symptoms?

11. DETAILED HISTORY

Please answer the all the questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they are all important to help diagnose and formulate a plan of action specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more details.
For medical history: Current = C; Past = P.

Include dates if possible for both if longer than 6 months ago.

Independent or Concurrent Therapies
1. __ Chiropractic
2. __ Chiro for Family / Pets
3. __ Acupuncture
4. __ Therapeutic Massage
5. __ Naturopathic
6. __ Oriental Medicine
7. __ Nutritional Consult
8. __ Medical Treatment
9. __ Specialist

Diagnostic or Routine Exams: Please list area, Dr. and reason ordered, date and location of exam if known.

Thank you very much for your time, and we look forward to work with you!

Patient Notification of Financial Responsibility

I understand that I am financially responsible for any charges incurred at this office, including charges denied or not covered by my insurance company.

I realize that due to the nature and extent of the care offered by Dr. Tyler Hurst at Berry Hill Chiropractic and Wellness, I may not be reimbursed by my insurance company, and I accept all responsibility for any treatments, which are determined to be medically necessary. I understand Dr. Tyler Hurst and the Berry Hill Chiropractic and Wellness staff is not required to submit documentation to the insurance company for services provided by Dr. Hurst.

Initials: ____________

I understand that Dr. Tyler Hurst and Berry Hill Chiropractic and Wellness reserve the right to charge 50% of the appointment cost for any appointments that are cancelled without 24 hours of notice.

Initials: ____________

If the undersigned fails to make any payments due hereunder, Dr. Tyler Hurst and Berry Hill Chiropractic and Wellness may at any time thereafter without notice or demand after, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise to pay all cost of collection including but not limited court cost, attorney fees equal to fifteen percent (15%) of any amount due and owing to Berry Hill Chiropractic and all other collection costs.

I have read and understand my obligations for payment for care at Berry Hill Chiropractic and Wellness

Print Name and Date ____________________________________

Sign and Date___________________________________