Atlantic Wellness Center Intake Information

Name_____ Date_____
Address_____ Referred by_____
City_____ST._____Zip_____ Occupation_____
Phone Home_____ Employer_____
Cell_____ Work Number_____
Date of Birth_____Sex Male__Female__ Martial Status_____
Social Security #_____ Spouses Name_____
E-Mail_____ Emergency Contact Name_____
Out of Town Address_____ Emergency Contact Number_____
_____ What do you prefer to be called_____

Center for **M**edicare and Medicaid **S**ervices (**CMS**) requires both race and ethnicity to be reported
Race: American Indian or Alaska Native___ Asian___ Black or African American___ White(Caucasian)____
Native Hawaiian or Pacifc Islander___ I Decline to Answer___ Other_____
Ethnicity: Hispanic or Latino____ Non Hispanic or Latino____ I Decline to Answer____

Health History Do you — How much and how long

Smoke	Yes___ No___	_____
Drink Alcohol	Yes___ No___	_____
Drink Coffee / Caffeine	Yes___ No___	_____
Exercise Regularly	Yes___ No___	_____
Use Vitamins/Supplements	Yes___ No___	_____
Previous Chiropractic Care	Yes___ No___	_____

Who is your current Medical Doctor_____

Medication Name	Dosage and Frequency
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

Allergies to medications with reactions_____
_____
Surgeries / Hospitalizations_____
Major Illnesses_____
Immunizations_____
Reported Tests (MRI,X-Ray,Ect.)_____

Family History	Heart Disease	Arthritis	Cancer	Stroke	Diabetes	Other
Father side	____	____	____	____	____	_____
Mother side	____	____	____	____	____	_____

Current Health Condition

Reason for your visit _____

_____

_____

_____

_____

Help Us Help You

Onset sudden (Date)_____ gradual____ continuing/recurring____ _____

Cause unknown____ accident____ (if auto ask for additional form)

Prior History none___ on/off for months___ years___ _____

Side left____ right____ both____

Any Change no change___ improving___ getting worse___

Quality achy___ burning___ dull___ sharp___ stiff___ throbbing___ other_____

Intensity mild____ moderate____ severe____

Frequency constant___ frequent___ intermittent___ occasional___ other_____

Radiation the pain travel to_____

_____

Level: 0-10 0 is no pain, 10 is severe pain 1__2__3__4__5__6__7__8__9__10__ range_____

What aggravates the pain

nothing___ driving___ lifting___ movement___ resting___ sleeping___ sitting___ standing___ walking___

What alleviates the pain

nothing___ cold/heat___ medications___ movement___ resting___ sleep___ walking___ chiropractic___

Headaches yes___ no___ if yes, location_____

How often do they occur and how long do they last_____

Intensity 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ range_____

Previous Interventions (name of doctor and treatment given)_____

_____

Current Height and Weight _____ feet _____ inches _____ Lbs.

// **Below line Staff use only** //

Present for intake spouse___ child___ caretaker___ friend___ other_____

Review of current condition_____

_____

_____

_____

_____

Numbness none___ mild___ mod___ sev___ area_____

Spasm none___ mild___ mod___ sev___ area_____

Weakness none___ mild___ mod___ sev___ area_____

Decreased motion and pain with movement_____

_____

_____

Blood Pressure_____