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 c urrent Medical Doctor___________________________________ May we contact them?____

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 0__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.

How did you hear about us? ______________________________

// **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______________________