



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 Medicare and Medicaid Services (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 Pacific 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

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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 _____