



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 _____ 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 _____