



Care. Educate. Serve

Blau Family CHIROPRACTIC & INTEGRATED WELLNESS

641 LATTON LANE
PORTAGE, WI 53901
(608) 742 - 1300
blauchiropractic.com



New Patient Intake

Name: _____ Today's Date: _____

Parents' Names (if you are under 18 only): _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Primary Phone (circle one) home/cell/work #: _____ Secondary Phone (circle one)

home/cell/work #: _____ Email Address: _____

Male Female Birth Date: _____ Current Age: _____ Marital Status: _____

Emergency Contact Name/Number: _____ Relationship: _____

Name and ages of spouse and children (if any): _____

Occupation: _____ Employer Name: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Current tobacco use status: Never smoked Former smoker Social/occasional smoker Every day smoker
Smoking start date (if any): _____ Smoking quit date (if any): _____

Have you seen a chiropractor before? Yes No If yes, when? : _____

Whom may we thank for referring you to our office? : _____

FOR WOMEN ONLY: Are you pregnant or trying? Yes Possible/Unknown No

Start date of your last period: _____ If pregnant, when is your due date? _____

Your Health Summary

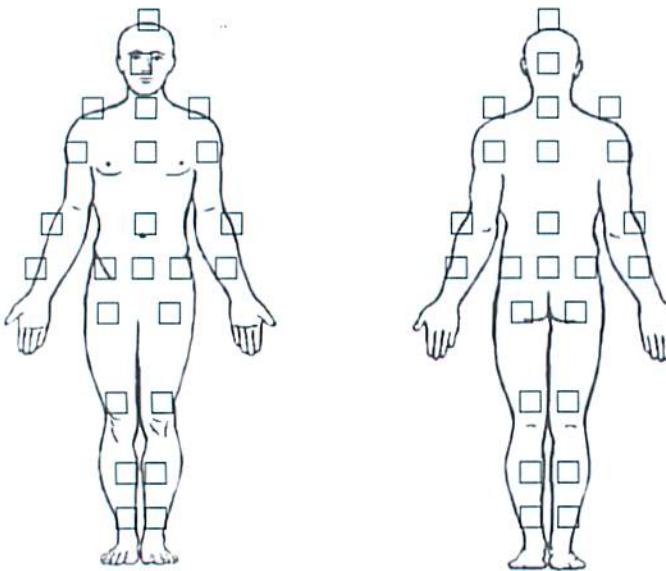
Please check all symptoms you have ever had, even if they do not seem related to your current problems

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headache | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Mental / Emotional Disorders | <input type="checkbox"/> Neck Pain R/L | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shoulder Pain R/L | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Swollen or Painful Joints | <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure |

Please check all symptoms (continued...)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Upper Back Pain / Stiffness | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Mid Back Pain / Stiffness |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Depression | <input type="checkbox"/> Pain with cough, or strain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Attention Disorder | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Low Back Pain / Stiffness |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Muscle Tightness |
| <input type="checkbox"/> Menstrual Problems / PMS | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Menopausal problems | <input type="checkbox"/> Learning Disability | |
| <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> Prostate Problems | |

Please check the appropriate boxes coordinating with where you are experiencing pain.



Please describe your pain in detail. (Ex: pins and needles on feet, pounding head, burning forearm pain, etc.)

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial here to indicate you have been made aware of its availability: _____

The statements made on this form are accurate and true to the best of my recollection and I agree to allow this office to examine me for further evaluation. By signing this form you are waiving receipt of a clinical summary after every visit. You have the right to request a copy of your notes at any time.

Patient (or guardian if under 18) Signature: _____ Date: _____