Blau Family CHIROPRACTIC & INTEGRATED WELLNESS
Care. Educate. Serve
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): _____

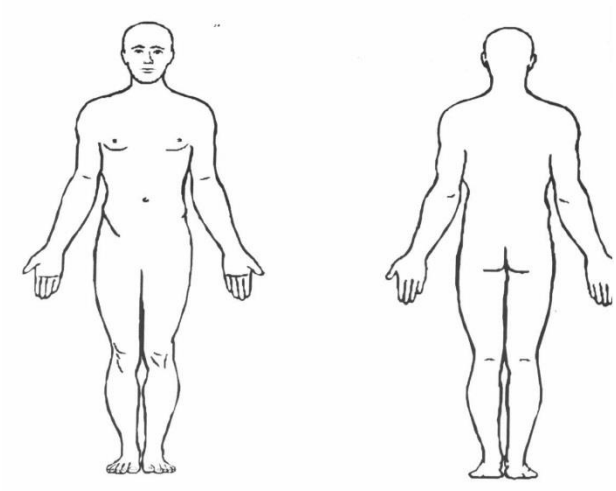
Have you seen a chiropractor before? ☐Yes ☐No If yes, when? : _____

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? _____

Please **X** the appropriate area where you are experiencing symptoms.



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

_____

_____

_____

_____

_____

Your Health Summary

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

☐Arthritis
☐Back Curvature
☐Mental / Emotional Disorders
☐Diabetes
☐Swollen or Painful Joints
☐Skin Problems
☐Bruise easily
☐Cancer
☐Allergies
☐Frequent Colds
☐Upper Back Pain / Stiffness
☐Excessive Gas
☐Constipation
☐Diarrhea
☐Impotence
☐Kidney Problems
☐Frequent Urination
☐ Menstrual Problems / PMS
☐ Menopausal problems
☐ Convulsions / Epilepsy
☐Headache
☐Migraine Headache
☐Neck Pain R/L
☐Shoulder Pain R/L
☐Numbness or Tingling
☐Carpal Tunnel Syndrome
☐Dizziness
☐Ringing in Ears
☐Hearing Loss
☐Loss of Balance
☐Digestive Problems
☐Depression
☐Attention Disorder
☐Anxiety Disorder
☐Eating Disorder
☐Trouble concentrating
☐Loss of memory
☐Ear Infection
☐Learning Disability
☐Prostate Problems
☐Asthma
☐Chest Pain
☐Difficult Breathing
☐Heart Problems
☐Heart Attack
☐High Blood Pressure
☐Low Blood Pressure
☐Varicose Veins
☐Liver Trouble
☐Gall Bladder Trouble
☐Mid Back Pain / Stiffness
☐Pain with cough, or strain
☐Hip Pain
☐Low Back Pain / Stiffness
☐Sciatica
☐Stroke
☐Muscle Tightness
☐Trouble sleeping

What **Activity of Daily Living** is most affected by your chief complaint? Please check √ **ONE**:

☐ Employment ☐ Lifting ☐ Sitting ☐ Social Life ☐ Traveling
☐ Homemaking ☐ Personal Care ☐ Sleeping ☐ Standing ☐ Walking

What do you have difficulty performing in reference to the specific complaint selected above?

Please check √ **ALL** that apply:

☐ Bending Over ☐ Exercising ☐ Looking over Shoulder ☐ Sitting
☐ Caring for Family ☐ Getting in/out of Car ☐ Making Love ☐ Standing
☐ Climbing Stairs ☐ Getting to Sleep ☐ Lying Down ☐ Staying Asleep
☐ Concentrating ☐ Grocery Shopping ☐ Reaching Overhead ☐ Using Computer
☐ Dressing Self ☐ Household Chores ☐ Rising out of chair/bed ☐ Walking
☐ Driving Car ☐ Lifting Objects ☐ Showering or Bathing ☐ Yard Work

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 and 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: _____