Akita Chiropractic Clinic Dr. Byron Akita, D.C. Dr. Timothy Akita, D.C.
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New Patient Intake Form

Name _____ **DOB** _____ **Date** _____

Male _____ Female ____ Height _____ Weight _____ Single _____ Married _____

Address _____ City _____ State ____ Zip_____

Home Phone _____ Email address _____

Cell Phone _____ Cell Carrier for text reminders _____

Employer _____ Occupation _____

Insurance Company _____ ID # _____

What is the reason for your visit today? _____

What caused your complaint? _____ Date pain began _____

Please circle your answers:

My pain started: immediately, slowly over time, quickly after injury

My symptoms are: constant, come and go, depends on activity. My condition is getting: better, worse, same

My pain feels: sharp, tight, dull ache, numb, burning, throbbing, stabbing, tingling

Does your pain radiate to other areas? Y/N Where? _____

My pain increases when I: sit, stand, stand up, bend, walk, reach, climb stairs, lift, get in and out of a car

Have you had a similar condition in the past? Y/N How often? _____

My pain interferes with: work, sleep, daily routine, recreation

What makes your pain better: ice, heat, bed rest, wraps or braces, traction, Aspirin, Tylenol, Advil, Naproxen, stretching, other _____

What other health provider have you seen for this condition? _____

What tests have you had for this condition: X-rays, CT/ MRI, Ultrasound, blood tests, _____

What other treatment have you had for this condition? _____

Do you exercise? Y/N How often? _____ What kind of exercise? _____

Do you smoke? never smoker, former smoker, sometimes smoker current everyday smoker

Do you drink alcohol? None, rarely, occasionally, weekly, daily

Allergies _____

Surgeries / year _____

Fractures / year _____

Auto Accidents / year _____

Are you a pregnant woman? Y/N What month? _____ Ages of other children _____

Name _____ DOB_____

List all medications you are currently taking and the dosages, including prescriptions, vitamins, etc.

_____

_____

Please circle all the conditions you have had or currently have:

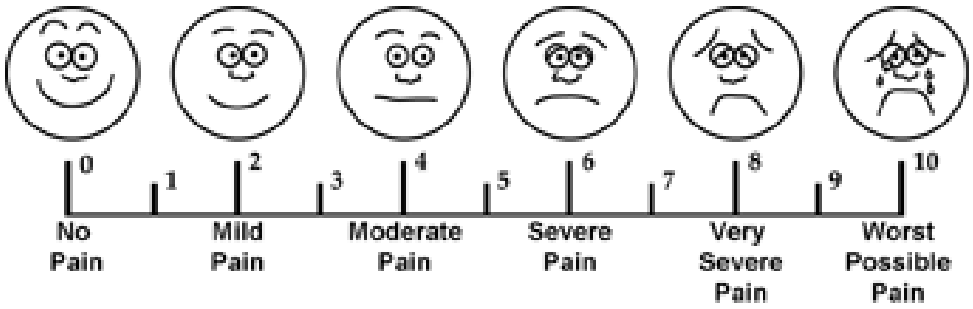
Recent infection
Recent fever
HIV/AIDS
Diabetes
Corticosteroid use
Arthritis
Stroke, give date:
High blood pressure
Dizziness, fainting
Deafness/Hearing Aid
Pain at night
Arm or hand numbness
Bleeding Disorder
Migraines/many headaches
Thyroid Disease
Sore that won't heal
Irregular Heartbeat/murmur
Urinary retention
Persistent cough
Multiple Sclerosis
Kidney Disease, stones
Pacemaker
Tuberculosis
High Cholesterol/ Triglycerides
Hands/feet: cold or hot
Stomach ulcer/bleeding ulcer
Prostate problems
Frequent urination
Abnormal weight gain or loss
Epilepsy/ Seizures
Visual Disturbances
Low Back Pain
Middle Back Pain
Neck Pain
Leg Pain or numbness
Cancer / Tumor
Osteoporosis
Asthma
Hepatitis / Liver Disease
Rheumatic Fever
Irregular moles
Aortic aneurysm
Severe Menstrual Pain
Herpes/Shingles/Chicken Pox
Mononucleosis
Tinnitus
Scoliosis
Acid Reflux disease
Shortness of breath
Emphysema
Other: _____

Family History: Please check all that apply to your family.

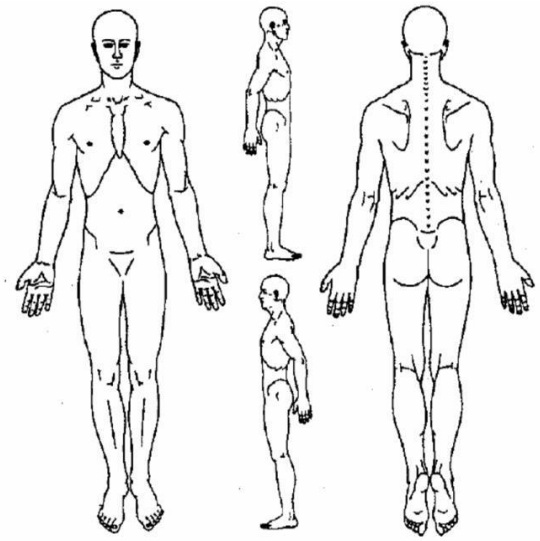
	Yes	No	Mother	Father	Sister	Brother	Grandmother	Grandfather
Arthritis								
Cancer								
Cardiovascular disease								
Diabetes								
Heart Disease								
High Blood Pressure								
Multiple Sclerosis								
Stroke								

Name _____ DOB_____

Please circle the face below to show how bad your pain has been recently:



Please circle your areas of pain:



Please present your current insurance card and photo ID to the receptionist.