Total Body Balance

Dr. Faith E. Leuschen, Chiropractor

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PATIENT INTAKE FORM

Name:_____Address:_____

City:_____State:_____Zip:_____Home Phn:_____Cell Phn:_____

Date of Birth:_____Age:_____SS#:_____Height:_____Weight:_____

Best Emails:_____

Male:___Female:____Single____Married___Divorced____# of Children____Name of Spouse_____

Who referred you to our office?_____

Employer:_____Occupation:_____

Work Phone:_____Work Address:_____

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Have you ever had Chiropractic Care before?_____ If yes, when_____

List your chief complaints in order of severity (Pain, Discomfort, Symptoms, ect...) and any other health issues:

1._____For how long?_____

2._____For how long?_____

3._____For how long?_____

4._____For how long?_____

5._____For how long?_____

Your Health and Wellbeing is My #1 Priority

Do you ever experience any of these complaints while working?_____ If YES, describe what activities at work that may be causing you to experience these complaints:_____
_____

Are there any other activities or events outside of work that may have caused these complaints? If YES, Please explain:_____
_____

If this is due to an injury or accident, what is the DATE OF INJURY OR ACCIDENT?_____

Has this problem been getting better, worse of staying the same?_____

What activities make your condition worse?_____

Have you ever had any surgeries or hospitalizations?_____ If YES, please list with the date of each below:

1._____
2._____
3._____
4._____
5._____

If you have more to add, please mention them to the Dr. Faith during your history and physical time.

Please indicate medications (over the counter and prescriptions) plus any supplements that you are currently taken:
_____

_____

Health Insurance:_____**Policy Holder**:_____
Note: **we are not in any HMO plans** if you have a PPO and it must cover Chiropractic in order for us to bill out.

Claims Address:_____

Policy Number:_____Group Number:_____

Secondary Insurance:_____**Policy Holder**:_____

Claims Address:_____

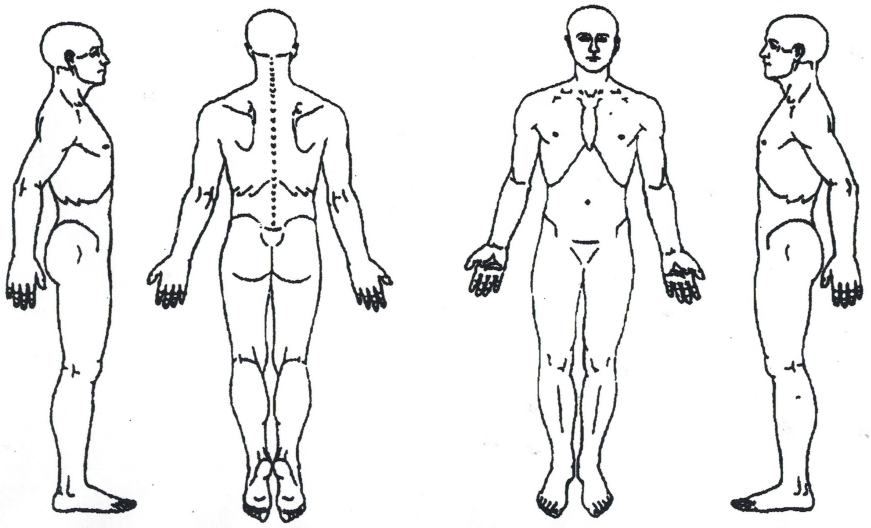
Policy Number:_____Group Number:_____

PAIN ASSESSMENT

Name: _____ Date: _____

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



Please be as descriptive as possible in the above human chart.
Circle the areas of pain and discomfort.
Let Dr. Faith know the type of pain that it is and whether you have numbness, tingling, sharp shooting pain, aching pain, deep dull aches, lack of sensation or however it is that you describe and experiences your symptoms.