DR. MASON ELBERT, DC
607 2ND STREET JACKSON, MN 5078497310

-ELBERT FAMILY- Chiropractic

PATIENT INTAKE FORM

Date: ______________

Patient Information

First Name: _______________________ **Middle Name:** __________________ **Last Name:** ________________________________

Home Phone: ________________________ **Work Phone:** _______________________ **Cell Phone:** ________________________

Email Address: ____

Address: ____

City: ____ **State:** ________________________ **Zip Code**: _______________________

Birthday: _____________ **Sex:** *(check one)* M___ F___ **Marital Status:** *(check one)* Married___ Single___ Other___

Spouse Name: ______________________ **Number of Children:** ____ **Chance Pregnant**: Y___ N___ **Height:** ____ **Weight:** _____

Emergency Contact: _______________________________________ **Relation:** ___________________ **Phone:** _______________

Referral Information

Referred By: *(check one)* Physician ___ Patient ___ Other ___ **Name of Referral:** ____

How did you hear about us? ____

Patient History

Last Physical Exam: *(month and year)* _______ **Primary Phys:** _________________ **Phys City:** ______________ **Phys State:** ____

Have you received chiropractic care in the past? *(check one)* Yes ___ No ___ - **IF YES-** **Date Received:** ____________________

Reason for Treatment: ____

Medications and Supplements: *(If you cannot remember, please bring an updated list at your next visit)* __________________

____

Please list any sprains/strains or broken bones *that are currently causing you pain* **in the space provided below (If none, leave blank):**____

Please list any recent surgeries or hospitalizations: ____

Please list any previous illnesses: ____

Eating Disorder: *(check one)* Yes___ No___ **Stroke**: *(check one)* Yes___ No___ **Struck Unconscious:** *(check one)* Yes___ No___
Auto Accident: *(check one)* Yes___ No___ **If you checked "Yes" for any of the four previous questions, please explain any treatment received in the space provided:** ____

Reason for Treatment

Current aches and/or pains*:* ____

When did this/these start to occur? ____

Specific event/events that may have onset aches/pains: ____

Do aches/pains radiate throughout your body? (*Please explain in space provided* →ex: (pain radiates from neck into right arm):
____

____

Rate the severity of aches/pains: *(circle number that best describes)* Mild → 1 2 3 Moderate → 4 5 6 Severe → 7 8 9 10

Frequency of aches/pains: *(check one)* Rarely (25%) ___ Occasionally (50%) ___ Frequently (75%) ___ Constant (100%) ___

Activities that relieve aches/pains: ____

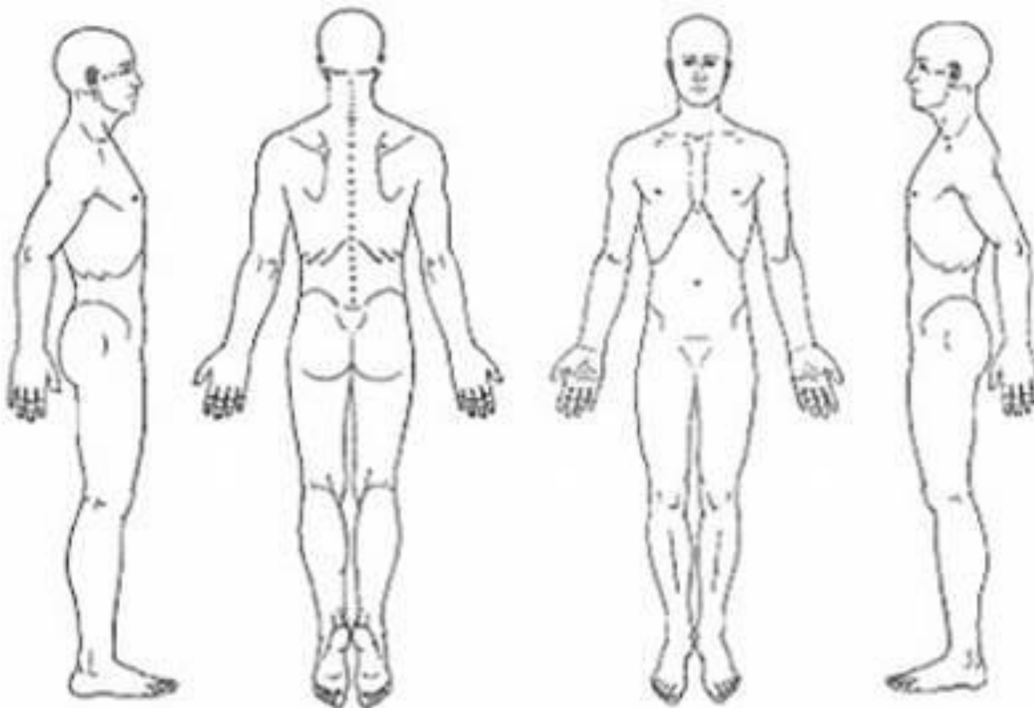
Activities that aggravate aches/pains: ____

Have aches/pains gotten better, worse or stayed the same over time? ____

Where is your pain located?

Please mark the location and character of your pain using the following symbols:

OO Dull **//** Sharp **^^** Stabbing **XX** Burning **++** Throbbing



Systems Review

Issues or complications with the following: *(Please check all that apply)* Bowel___ Bladder___ Digestion___ Tingling___ Numb___ Vision___ Heart___ Lungs___ Skin___ Hormones___ Other___

Describe any issues or complications checked above: ____

Daily Habits

How often do you use the following? *(Check frequency that applies)*

Alcohol: Daily___ Weekly___ Occasionally___ Never___ Caffeine: Daily___ Weekly___ Occasionally___ Never___

Recreational Drugs: Daily___ Weekly___ Occasionally___ Never___ Tobacco: Daily___ Weekly___ Occasionally___ Never___

Soft Drinks: Daily___ Weekly___ Occasionally___ Never___ Water: Daily___ Weekly___ Occasionally___ Never___

Current diet and nutrition habits*:* ____

Current exercise habits: ____

Employer Information

Employed: (check one) Full Time___ Part Time___ Unemployed___ **Job Title:** ____

Employer Name: ___________________________________ Employer City: ______________________ Employer State: _____

Patient Signature: ____ Date: ____________