



Natural Elements Health Center
Christine Schlenker, D.C., Chiropractor

900 Hwy 23 W Suite 3
Milaca, MN 56353
Tel: 320.983.2333 Fax: 320.983.5444

Chiropractic Intake Form

Today's Date: ___/___/___

Your Name: _____ Name you prefer to be called: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Sex: ___ M ___ F Marital Status: ___ Single ___ Married ___ Widowed Birthdate: ___/___/___

SS # (for insurance purposes): _____ E-Mail: _____

Best Place to reach you: Home Work Cell:() _____ AM PM ANYTIME

Occupation: _____ Employer: _____

Work Phone: _____

Spouse's/Partner's Name (if applicable): _____ Spouse's Birthdate (insurance purposes): ___/___/___

Children's Names and ages (if applicable): _____

Emergency Contact Name: _____ Phone: _____

Are your symptoms related to an accident? Y N Automobile Work Other Date: ___/___/___

I HAVE NO INSURANCE COVERAGE AT THIS TIME

Relationship to Insured: Self Spouse Child Other: _____

Who is your primary care doctor? _____

(Please list name and facility)

May we contact him or her about your care? Y N Were you referred by him or her? Y or N

How did you hear about us? _____

Current Complaints

Major complaints and symptoms: 1) _____
2) _____
3) _____

How do you believe your problem (pain) began? _____

On a Scale of 0—10, I rate my discomfort as follows:
(zero being no pain, 10 being the worst pain I have ever felt)

Neck-Shoulder-Arm Pain	(_____)
	0 10
	No pain severe pain
Mid Back Pain	(_____)
	0 10
	No pain severe pain
Low Back- Leg Pain	(_____)
	0 10
	No pain severe pain

How often do you experience your symptoms?

Constantly (76-100% of day)
 Frequently (51-75% of day)
 Occasionally (26-50% of day)
 Intermittently (0-25% of day)

How would you describe your symptoms?

Sharp Shooting Dull Ache Burning Numb
 Tingling Other: _____

How are your symptoms changing?

Getting better Not changing Getting Worse

Do you have/ had any of the following conditions? Please check if "Yes":

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Anemia
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Attack

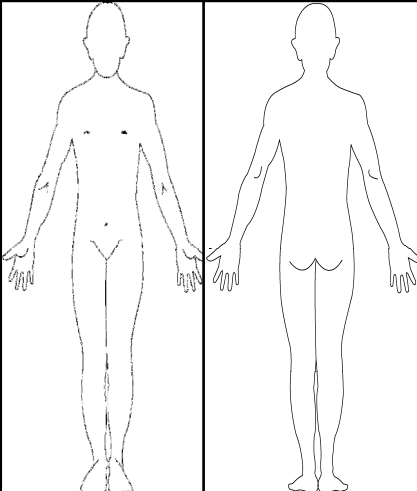
List any broken bones, dislocations, head injuries, significant falls or surgeries and approximate dates:

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

Vitamins and Supplements _____ _____ _____ _____	Allergies _____ _____ _____	Medications (please write additional on separate sheet of paper) _____ _____ _____ _____
---	---	---

Family History: Please check the box if any immediate family members have had any of the following: <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Lupus <input type="checkbox"/> Cancer: _____	Social History SMOKER Yes ___ No ___ If Yes, how many packs per day? _____ #of years? _____ ALCOHOL Yes ___ No ___	EXERCISE Yes ___ No ___ If Yes, how many days per week? _____ What length of time are you active per Exercise session? _____
---	---	--

Male Only Section Any burning when you urinate? Yes ___ No ___ Any trouble starting/stopping urine flow? Yes ___ No ___ Have you had cancer? Yes ___ No ___ If so, what type and when? _____	SHOW AREA(S) OF PAIN OR UNUSUAL FEELING Mark the areas on this body where you feel the described sensations.	Do you have a headache or head pain that is unlike any you have had before? Yes ___ No ___ Do you have a change in any wart or mole? Yes ___ No ___ Do you have a nagging cough or hoarseness? Yes ___ No ___
---	--	--

Female Only Section Currently Pregnant? Yes ___ No ___ Past Pregnancies: Yes ___ No ___ How many total? _____ Miscarriages? _____ Do you take birth control pills? Yes ___ No ___ Painful Menstruation? Yes ___ No ___ Tenderness/thickening of breasts? Yes ___ No ___ Have you had cancer? Yes ___ No ___ If so, what type and when? _____ Hormone Replacement Therapy? Yes ___ No ___ Date of onset of your last menses? _____		Does your pain ever wake you from a sound sleep? Yes ___ No ___ Are you losing weight now without trying? Yes ___ No ___ Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___ Have you had any loss of bladder or bowel control? Yes ___ No ___ Have you even been or are you now being pressured or forced to engage in any type of Sexual activity? Yes ___ No ___
---	---	--

Please check if you have had any of these symptoms below. **Present is equivalent to within the past 12 months.**

	Present	Past		Present	Past		Present	Past
Headaches	___	___	Fainting/Dizzy	___	___	Loss of Balance	___	___
Migraines	___	___	Depression	___	___	Loss of Smell	___	___
Jaw Pain	___	___	Fatigue	___	___	Loss of Taste	___	___
Shoulder/Neck/Arm Pain	___	___	Tension/ Stress	___	___	Change in Vision	___	___
Pins & Needles in Arms	___	___	Irritability	___	___	Loss of Memory	___	___
Weakness in Arms	___	___	Frequent Colds	___	___	Hearing Changes	___	___
Numbness in Fingers	___	___	Indigestion	___	___	Buzz/ring in ears	___	___
Back/low back/hip Pain	___	___	Constipation	___	___	Flushed /red face	___	___
Knee or ankle pain	___	___	Hemorrhoids	___	___	Sinus Problems	___	___
Pins & Needles in Legs	___	___	Diarrhea	___	___	Allergies/hayfever	___	___
Weakness in Legs	___	___	Cold Sweats	___	___	Feet/hands Cold	___	___
Numbness in Toes	___	___	Night Sweats	___	___	Swollen joints	___	___
Leg Cramps	___	___	Seizures	___	___	Shortness of Breath	___	___
Chest Pains	___	___	Sleeping Problems	___	___			
Heart Problems	___	___						
Muscle Spasms	___	___						

Patient Signature: _____ **Date:** ___/___/___

** By signing above, all information on this intake form is true and accurate to the best of my knowledge.