Saleeby Chiropractic Centre, P.A.

Stephen M. Saleeby, D.C.
Wayne J. Prickett, D.C.

Today's Date: ____/____/____ Z: ___________

Chiropractic Intake

Name: ____ DOB: ___/___/___ Age:_______
First MI Last

Preferred Name:_______________________________

Address_______________________________ City________________ State __________ Zip Code _________

H. Phone ___________________________W. Phone________________ Cell Phone _____________________

Email Address: ______________________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other

Last 4 of Social Security #_____________ # Children ______ Ages: _______

Employer_________________________________ Occupation: ______________________________________

Work Address: _______________________________________City:_____________ State:_______ Zip:______________

Spouse/Parent Name: ____ Phone #:___________________________

Spouse/Parent Employer:____ Work #:______________________________

Emergency Contact:____ Phone#:________________________

Referred by: _______________________________________

Your Primary Care Physician ____________________________ Last Exam_____________________________________

Do you have health insurance? ☐ Yes ☐ No Insurance Company:__________________________

Primary Insured's Name:________________________________ Insured's DOB: ______/_____/_____

Reason For Your Visit

☐ Pain Symptoms ☐ Wellness Visit ☐ Auto Accident ☐ Work Related Injury

☐ Sports Injury ☐ Other Injury:___________________________________

Date of Injury / Onset of Symptoms:___________________________________

Have you ever received Chiropractic Care? Yes No If yes, when? ___________________

Name of most recent Chiropractor: ____

3814 Browning Place, Suite 102, Raleigh, North Carolina 27609
919-782-4733 Fax 919-783-8225

1. Reasons for seeking chiropractic care:

Primary reason:

____

Secondary reason:

____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____

____

____

3. Past Health History:

A. Previous illnesses you've had in your life:

____

B. Previous Injury or Trauma:

____

Have you ever broken any bones? Which?

____

C. Allergies:

____

D. Medications:

Medication Reason for taking

____

____

____

E. Surgeries:

Date Type of Surgery

____

____

____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____

____

____

4. Family Health History:

Associated health problems of relatives:

____

____

Deaths in immediate family:
Cause of parents or siblings death Age at death

____

____

____

3814 Browning Place, Suite 102, Raleigh, North Carolina 27609
919-782-4733 Fax 919-783-8225

5. **Social and Occupational History:**

A. Job description:

____

B. Work schedule:

____

C. Recreational activities:

____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

____

Your Medical History: (Check all that apply) (Y: Yourself F: Family Member)

Y F	Y F	Y F	Y F
☐ ☐ Fatigue	☐ ☐ Dizziness / Vertigo	☐ ☐ Fainting	☐ ☐ Cold Hands
☐ ☐ Cold Feet	☐ ☐ Hand Tremors	☐ ☐ Nausea	☐ ☐ Diarrhea
☐ ☐ Constipation	☐ ☐ Varicose Veins	☐ ☐ Stroke	☐ ☐ Difficulty Breathing
☐ ☐ Coughing Blood	☐ ☐ Bleeding	☐ ☐ Sweats	☐ ☐ Pregnancy
☐ ☐ Prostate Problems	☐ ☐ Heart Attack	☐ ☐ Circulatory Problems	☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure	☐ ☐ Ulcers	☐ ☐ Heart Problems	☐ ☐ Pacemaker
☐ ☐ Diabetes	☐ ☐ Alzheimer's	☐ ☐ Gallbladder Problems	☐ ☐ Digestive Problems
☐ ☐ Eczema	☐ ☐ Convulsions	☐ ☐ Tumors	☐ ☐ Seizures
☐ ☐ Epilepsy	☐ ☐ Tinnitus	☐ ☐ Headaches	☐ ☐ Migraines
☐ ☐ Eye/ Vision Problems	☐ ☐ Ear/hearing problems	☐ ☐ Arthritis	☐ ☐ Osteoarthritis
☐ ☐ Rheumatoid Arthritis	☐ ☐ Osteoporosis	☐ ☐ HIV/AIDS	☐ ☐ Congenital Disease
☐ ☐ Ruptures	☐ ☐ Disc Disorder	☐ ☐ Speech Difficulty	☐ ☐ Loss of Memory
☐ ☐ Confusion	☐ ☐ Nervousness	☐ ☐ Anxiety	☐ ☐ Mental Illness
☐ ☐ Irritability	☐ ☐ Tension	☐ ☐ Depression	☐ ☐ Insomnia
☐ ☐ Eating Disorder	☐ ☐ Alcoholism	☐ ☐ Drug Addiction	☐ ☐ Scoliosis
☐ ☐ Tonsillitis	☐ ☐ Kidney Disorder	☐ ☐ Gout	☐ ☐ Neuralgia
☐ ☐ Chills	☐ ☐ Earache	☐ ☐ Sciatica	☐ ☐ Amputation
☐ ☐ Vomiting	☐ ☐ Hemorrhoids	☐ ☐ Bursitis	☐ ☐ COPD
☐ ☐ Broken / Fractured Bones	☐ ☐ Neuro-Muscular Disease	☐ ☐ Loss of Bladder Control	☐ ☐ Loss of Bowel Control
☐ ☐ Cancer:	☐ ☐ Other:	☐ ☐ Other:	☐ ☐ Other:

Which Activities are difficult due to your Pain / Discomfort?

☐ Sleeping	☐ Walking	☐ Standing	☐ Sitting	☐ Running
☐ Climbing	☐ Bathing	☐ Showering	☐ Dressing	☐ Shoes
☐ Toileting	☐ Cleaning	☐ Self Care	☐ Family Care	☐ Child Care
☐ Home Care	☐ Driving	☐ Gardening	☐ Working	☐ Lifting
☐ Desk Work	☐ Traveling	☐ School	☐ Concentrating	☐ Other:

3814 Browning Place, Suite 102, Raleigh, North Carolina 27609
919-782-4733 Fax 919-783-8225

NEW PATIENT HISTORY FORM

Symptom 1 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

3814 Browning Place, Suite 102, Raleigh, North Carolina 27609
919-782-4733 Fax 919-783-8225

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including my deductibles, and further understand that the estimated co-pay is neither a guarantee of payment by insurance company, nor necessarily an accurate reflection of my actual co-pay as determined by my insurance company upon processing my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time upon request of this office, I will immediately pay the balance on my account. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information I have provided is true and complete, to the best of my knowledge.

Patient's Signature:____

Date:_________/_________/_________

3814 Browning Place, Suite 102, Raleigh, North Carolina 27609
919-782-4733 Fax 919-783-8225