

Flamingo Neck & Back

Intake Form

3585 E. Flamingo Road Ste. 202

Las Vegas, NV 89121

(Please print or circle where indicated)

Today's Date: _____

Are your **current** complaints related to a motor vehicle accident or a work-related injury? Y N

Last Name: _____ First Name: _____ Middle Initial: _____

Policy or Social Security #: _____ Date of Birth: ____/____/____ Gender: M F

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____ Work Phone: () _____ - _____

Indicate which number is best to reach you: Home Cell Work

Email Address: _____ May we contact you by email? Y N

Occupation: _____ Employer: _____

Do you work: Full-time Part-time Retired N/A ?

Marital Status: M S W D If Married, Spouse's Name: _____

Have you ever had chiropractic treatment? Yes No If so, date of last treatment: _____

Insurance Information if Not Self

Last Name: _____ First Name: _____ Middle Initial: _____

Policy or Social Security #: _____ Group #: _____

Date of Birth: ____/____/____ Your Relationship to the Insured: Spouse Dependent Other

Referral Information

Who can we thank for referring you to our office?

Name: Mr./Ms./Dr. _____ Clinic: _____

Family History

	Back	Heart	Stroke	Cancer	Diabetes	High Blood Pressure	Arthritis	High Cholesterol	Osteoporosis	Thyroid
Mother										
Father										
# of Sisters _____										
# of Brothers _____										
# of Children _____										

Social History

Height: _____ Weight: _____

Do you?	Daily	3x/week	2x/week	1x/week	2x/month	1x/month	Never
Use Tobacco/Smoke							
Exercise							
Work at Computer							
Sit at a Desk							
Work on a Phone							
Alcoholic Beverages							
Moderate/Heavy Labor							
Stay at Home							
Deliver Packages							

Medical History

Serious Illness: Please circle any condition for which you have ever received examination or treatment.

Alcohol/Drug Addiction	Anemia	Arrhythmia	Arthritis
Asthma	Backaches	Bleeding Disorder	Blood Clots
Blood Transfusions	Blurred Vision	Bowel Problems	Broken Bones
Cancer	Carpal Tunnel	Cataracts	Chicken Pox
Colitis	Collagen Vascular Disease	Constipation	Depression/Anxiety
Diabetes	Digestive Disorders	Dizziness	Eating Disorder
Emphysema	Epilepsy	Fatigue	Female Health Challenges
Gallbladder Disease	Genital Herpes	Glaucoma	Gluten Intolerance
Gout	Headaches	Hearing Loss	Heart Disease/Attacks
Heart Murmur	Hemorrhoids	Hepatitis	High Blood Pressure
High Cholesterol	HIV/AIDS	Joint/Back Pain	Kidney Infections
Kidney Stones	Liver Disease/Problems	Lung Disease	Menstrual Cramps
Mental Disorder	Migraines	Neck Pain	Nervousness
Night Sweats	Osteoporosis	Paralysis	Pneumonia
Polio	Prostate Problems	Reflux/Ulcers	Rheumatic Fever
Seizures/Epilepsy	Sexual Dysfunction	Sickle Cell	Sinus Trouble
Stress/Tension	Stroke	Suicidal Tendencies	Thyroid Disease
Tuberculosis	Tumors	Urine Discoloration	Vertigo

Surgical History PLEASE DO NOT EXCLUDE ANY

Surgery Name	Date Performed (Year)

Allergies

Allergy Name	Date Detected

Current Medications

Name of Medication	Reason for Taking Medication

Accident History

Enter all auto accidents, slips & falls, sports or work related injuries that you have had in the past

Accident Type	Date	Chiropractic Treatment Received	
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall		Yes	No
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall		Yes	No
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall		Yes	No
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall		Yes	No
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall		Yes	No
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall		Yes	No

Current Complaints

Please use the following sections to list and describe each complaint separately.

What is your **FIRST** complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING
 POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING
 THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

What is your **SECOND** complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING
 POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING
 THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

What is your THIRD complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING
 POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING
 THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

What is your FOURTH complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING
 POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING
 THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

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Maintenance of Health Care Records

According to NRS 629.051 of the Nevada law, health care providers must retain the health care records of all patients as part of his or her regularly maintained records for 5 years. If a patient has not received treatment after 5 years the records may be destroyed. The records of a patient less than 23 years of age must not be destroyed until such an age has been reached.

I, _____, have read and understand the policy of Flamingo Chiropractic regarding the retention and destruction of my health records.

Patient/Guardian Signature

Date

A signed copy of this policy will be kept as a part of your medical records; you will receive the original.