



Dopps Chiropractic
555 N McLean Blvd.
Wichita KS, 67203
Phone: 316-265-3544
www.doppsclinic.com

Patient Intake Form

Date, First Name, Last Name, DOB, Sex, SSN, Address, City, State, Zip Code, Phone 1, Phone 2, Fax, Email, Employer, Employer Phone, Occupation, Job Status, Marital Status, Receive Appointment Reminders, Height, Weight

Reason for Visit: New Patient, Adjustment, Physical, Consultation, X-Rays, Therapy, Injury, Report of Findings, Auto Accident, Re-Examination, Other

Referred by: Provider, Friend, Family, Other, Referred by Name

How Heard of Us: Walk in, Referral, Phone Book, Website, Advertisement, Other

Demographics

Race: White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Specific Islander, Other

Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Unknown, Other

Dominance: Right, Left, Ambidextrous

Insurance Information

Primary Insurance: Insured First Name, Last Name, DOB, Insurance Name, Insurance Phone, ID #, Group #, Relationship to Insured, Visit Copay, Co-Ins. %, Deductible, Applied, \$/Year, Visits/Year, Therapy Visits/Year, PCP Referral Required, Policy Effective Date, Cal Yr / Other, Other

**Secondary Insurance:**

Insured First Name \_\_\_\_\_  
Insured Last Name \_\_\_\_\_  
DOB \_\_\_\_\_  
Insurance Name \_\_\_\_\_  
Insurance Phone \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Relationship to Insured  Self  Spouse  Child  Other

Visit Copay \_\_\_\_\_  
Co-Ins. % \_\_\_\_\_  
Deductible \_\_\_\_\_ Applied \_\_\_\_\_  
\$/Year \_\_\_\_\_ Visits/Year \_\_\_\_\_ Therapy Visits/Year \_\_\_\_\_  
PCP Referral Required  Yes  No  
Policy Effective Date \_\_\_\_\_  
Cal Yr / Other \_\_\_\_\_  
Other \_\_\_\_\_

**Emergency Contact Information**

First Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last Name \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

**Health History**

**Medications/Vitamins/Supplements:**


**Allergies:**


**Illnesses:** Please check all that apply

- AIDS/HIV       Chronic Fatigue       Heart Disease       Miscarriage       Seizures
- Anemia       Depression       Hepatitis       Multiple Sclerosis       Stroke
- Arthritis       Diabetes       Hernia       Osteoporosis       Suicide Attempt
- Asthma       Emphysema       Herniated Disc       Pacemaker       Thyroid Problems
- Bleeding Disorders       Epilepsy       High Blood Pressure       Parkinson's Disease       Tuberculosis
- Breast Lump       Fibromyalgia       High Cholesterol       Pinched Nerve       Tumors/Growths
- Bronchitis       Fractures       Immune Deficiency       Prostate Problems       Ulcers
- Cancer       Gallstones       Kidney Disease       Prosthesis       Vaginal Infections
- Chemical Dependency       Glaucoma       Liver Disease       Psychiatric Disorder       Venereal Disease
- Chicken Pox       Gout       Migraine Headaches       Rheumatoid Arthritis       Whooping Cough
- Other \_\_\_\_\_

Is there any history in your family for any of the above conditions?

Who? \_\_\_\_\_

What did they have? \_\_\_\_\_

**Surgeries:**


**Traumas:**


**Complaints:** (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

**Does the pain travel anywhere else?** \_\_\_\_\_

**Do you know what caused the problem?** \_\_\_\_\_

**Do you notice the pain during a certain time of day?** \_\_\_\_\_

**Frequency:** \_\_\_\_\_ times per  Day  Week  Month  Year

**Duration:** Lasting \_\_\_\_\_  Minutes  Hours

**Onset:** Have had symptoms over the past \_\_\_\_\_  Days  Weeks  Months  Years

**Intensity:**  Minimal  Slight  Moderate  Severe

**Is your condition:**  Same  Better  Worse

**Rate your pain:**  0  1  2  3  4  5  6  7  8  9  10

*0 being no pain at all and 10 being the worst pain imaginable*

**Quality: Describe your pain:**  aching  burning  cramping  deep  dull  numb  radiating  sharp  
 shooting  sore  stabbing  stiff  swelling  tight  tingling  throbbing

**Aggravating Factors: What makes the problem worse?**  nothing  most movements  bending  carrying things  
 coughing  driving  eating  exercise  going down stairs  going from lying to sitting  
 going from lying to standing  going from sitting to standing  heat  housework  ice  jogging  lifting  
 lying down  massage  pulling  pushing  running  sitting  sleeping  sneezing  squatting  
 standing  standing for a long period of time  stress  stretching  taking a deep breath  turning  
 twisting  walking  working

**Relieving Factors: What makes the problem better?**  nothing  anti-inflammatories  bracing  chiropractic care  
 elevation  exercise  heat  ice  massage  movement  pain killers  rest  stretching  
 walking  wraps

**What daily activities are affected due to the problem?**  bathing  caring for children  cleaning  climbing stairs  
 cooking  doing laundry  dressing  driving  eating  exercising  going from laying down to sitting  
 going from sitting to standing  grooming  house work  laying down  lifting  oral care  sex  
 shopping  sitting  sleeping  social/recreational activities  standing  stretching  toileting  
 transferring  using technology  using phone  walking  watching tv  working  yard work

**Have you been given a diagnosis for this problem? If so, what was the diagnosis?** \_\_\_\_\_

**What treatment(s) have you tried for your condition?**  None  Medication  Surgery  Physical Therapy  
 Chiropractic  Other \_\_\_\_\_

**Are you presently under the care of a physical and/or mental health care provider?** If so, by whom? \_\_\_\_\_

If so, what conditions? \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_ By whom? \_\_\_\_\_

**Energy Level:** Good    Insufficient    Erratic

Low (Time of Day) \_\_\_\_\_  High (Time of Day) \_\_\_\_\_

**Sleep:**  Trouble falling asleep     Trouble staying asleep     Restful     Other \_\_\_\_\_

**Stress:**  None     Low     Moderate     Severe    What causes stress? \_\_\_\_\_

**Have you had unexpected weight loss in the last 6 months?**     Yes     No    If yes, how much? \_\_\_\_\_

## Daily Habits

**Do you smoke?**  Never smoked     Unknown if ever smoked     Unknown if currently smokes

Current every day smoker     Current some day smoker     Former smoker

If yes, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Daily Caffeinated Beverages:**     Unknown     None     1 to 3     4 to 6     7 to 10     11 to 15     16 to 20     21 to 25     Over 25

**Weekly Alcoholic Drinks:**     Unknown     None     1 to 3     4 to 6     7 to 10     11 to 15     16 to 20     21 to 25     Over 25

**Do you exercise regularly?**     no     light     moderate     heavy

## Review of Systems

**Musculoskeletal:** Please check all that apply     None

Arm/hand pain     back pain     Feet/leg pain     hip     Knee     Lower back pain     Mid back pain     Muscle or joint pain

Neck pain     Redness of joints     Shoulder(s) pain     Stiffness     Swelling of joints     Upper back pain

**Cardiovascular/Respiratory:** Please check all that apply     None

Chest pain, pressure or discomfort     Cold hands/feet     Coughing up blood (hemoptysis)     Coughing up phlegm

Difficulty breathing     Dizziness/lightheaded     Fainting     Irregular heartbeat     Palpitations     Persistent Coughing

Shortness of breath     Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

Swelling (edema)     Tightness in chest     Wheezing     Other \_\_\_\_\_

**Head/Neck:** Please check all that apply     None

Dizziness     Facial pain     Grinding Teeth     Headache     Head injury     Hoarseness     Jaw Clicks     Lumps

Migraines     Pain     Sore throat     Stiffness     Swollen Glands     Tooth problems     Trouble swallowing

Other \_\_\_\_\_

**Eyes:** Please check all that apply     None

Blurred Vision     Burning     Cataracts     Double vision     Dryness     Flashing lights     Glasses/Contacts     Glaucoma

Itching     Pain     Redness     Specks     Vision Problems     Other \_\_\_\_\_

**Ears:** Please check all that apply     None

Buzzing in ears     Decreased hearing     Drainage     Earache     Ear infections     Poor balance     Poor hearing

Ringing in ears (tinnitus)     Other \_\_\_\_\_

**Nose:** Please check all that apply  None

- Allergies  Blocked Sinuses  Discharge  Excessive mucus  Hay fever  Itching  Nose bleeds  
 Sinus pressure/pain  Stuffiness/blockage  Other \_\_\_\_\_

**Throat/Mouth:** Please check all that apply  None

- Bleeding  Blue lips  Braces  Dentures  Difficulty swallowing  Dry mouth  Hoarseness  
 Mouth pain  Non healing sores  Redness  Sore throat  Sores on lips or tongue  Swelling  
 Thrush  Tooth pain  Other \_\_\_\_\_

**Urinary:** Please check all that apply  None

- Blood in urine (hematuria)  Burning or pain  Difficulty urinating  Frequent urinary tract infections  
 Frequent urination  Incontinence  Kidney infections  Kidney stones  Unable to hold urine (incontinence)  
 Up at night to urinate  Urgency  Water retention  Other \_\_\_\_\_

**Gastrointestinal:** Please check all that apply  None

- Change in appetite  Change in bowl habits  Constipation  Diarrhea  Heartburn  Nausea  
 Rectal bleeding  Swallowing difficulties  Yellow eyes or skin (jaundice)  Other \_\_\_\_\_

**Endocrine:** Please check all that apply  None

- Change in appetite  Cold intolerance  Constipation  Diarrhea  Dry skin  Excessive thirst  
 Frequent urination  Heat intolerance  Sweating

**Vascular/Hematologic:** Please check all that apply  None

- Calf pain with walking (claudication)  Cold hands and feet  Ease of bleeding  Ease of bruising  Leg cramping

**Neurologic:** Please check all that apply  None

- Dizziness  Easily angered/irritated  Fainting  Frequent crying  Memory confusion  Nervousness  Neuralgia  
 Numbness  Poor concentration  Seizures  Suicidal thoughts  Tingling  Tremors  Weakness  
 Worry/anxiety  Other \_\_\_\_\_

**Psychiatric:** Please check all that apply  None

- Anxiety  Depression  Memory loss  Nervousness  Stress  Other \_\_\_\_\_

**Female:**

- Are you pregnant?  Yes  No Date of last period \_\_\_\_\_ Number of days between periods \_\_\_\_\_  
Age started \_\_\_\_\_ Age stopped \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_ Number of miscarriages \_\_\_\_\_  
Number of abortions \_\_\_\_\_ Number of Cesareans \_\_\_\_\_ Operations  Cervix  Uterus  Ovaries

Please check all that apply  None

- Clotting  Dark color  Discharge  Food cravings  Heavy bleeding  Hot flashes  Infections
- Irregular periods  Itching or rash  Leg cramps  Light bleeding  Little/no sex drive  Menstrual pain/cramps
- Missed periods  Mood swings  Painful breasts  Pain with sex  STD's  Vaginal discharge
- Vaginal dryness  Vaginal sores  Water retention  Other \_\_\_\_\_

**Male:** Please check all that apply  None

- Discharges  Erectile dysfunction  Hernia  Impotence  Low sex drive  Masses or pain  Painful urination
- Pain with sex  Painful discharge  Prostate problems  Sores  STD's  Other \_\_\_\_\_

### Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

### Payment policy

Dopps Chiropractic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status; I am ultimately responsible for any charges for professional services rendered by Dopps Chiropractic.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative Date \_\_\_\_\_

\_\_\_\_\_  
 Print Name of Patient, Parent, Guardian or Personal Representative Date \_\_\_\_\_