Finger Lakes Chiropractic

Danielle E. Ryan, DC

Medical Intake Form

Address: ____
____

Occupation: ____________________________ Phone: __________

Referral by __________________________ DOB: __________ Age: ___

Name (Last, First): ____ Date: __________

Known Allergies: ____ ☐ NKA (No Known Allergies)

Please mark the any of the following problems you are currently experiencing

General
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Mental Illness
- ☐ Tremors
- ☐ Weight Gain/Loss
- ☐ Head Trauma/Injury

Respiratory
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Respiratory Infection
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Other ______________

Muscle / Bone / Joint
- ☐ Chronic Pain
  - Where: ______________
  - How Long: ____________
- ☐ Disc Herniation
- ☐ Fracture/Dislocation
- ☐ Arthritis
- ☐ Spinal Deformity
- ☐ Joint Pain
- ☐ Other __________

Gastrointestinal
- ☐ Ulcer/Upper GI Bleeding
- ☐ Lower GI Bleeding
- ☐ Hemorrhoids
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Bloody/Tarry Stool
- ☐ Vomiting
- ☐ Nausea
- ☐ Other ________________

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Pacemaker
- ☐ Bleeding Disorder
- ☐ Blood Clot/Phlebitis
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Circulation Problems
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Other _______________

Genitourinary
- ☐ Urinary Tract Infection
- ☐ Bladder Infection
- ☐ Kidney Stone
- ☐ Painful Urination
- ☐ Increased Frequency of
- ☐ Change in Flow/Force of
- ☐ Other _______________

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, Supplements)

Name	Dose/Frequency	Reason	Doctor

Other Conditions
- ☐ Alcoholism
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Goiter
- ☐ STD

Comments (further explanation of any of the above): ____
____

Habits	No	Yes	
Smoking	☐	☐	Packs/day _____
Alcohol	☐	☐	Drinks/wk _____
Exercise	☐	☐	Hrs/wk _______
Sleep	☐	☐	Hrs/wk _______
Prolonged Sitting	☐	☐	Hrs/wk _______
Salty foods	☐	☐	____________
Healthy diet	☐	☐	____________

Hospitalizations (Include surgeries, drug/alcohol rehabilitations)

Date	Hospital	Reason	Doctor

Female History

Menstrual cramps
☐ Mild ☐ Moderate ☐ Severe

Are you pregnant?
☐ No ☐ Yes - Months _________

Last menstrual period: ______________

Pregnancy history: Children ___________

☐ Live births ____ ☐ Still births ____

☐ Miscarriages ____ ☐ Abortions _____

Family History

Father	☐ Alive	☐ Deceased	Medical problems:	____________________
Mother	☐ Alive	☐ Deceased	Medical problems:	____________________
Siblings	☐ Alive	☐ Deceased	Medical problems:	____________________

☐ Family history unknown

☐ Significant other conditions in family history ____________________

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Present complaint and reason for seeking care: ____

How long have you had this problem?____

Is this problem getting worse? ☐ No ☐ Yes

Have you seen anyone else regarding this complaint? ☐ No ☐ Yes

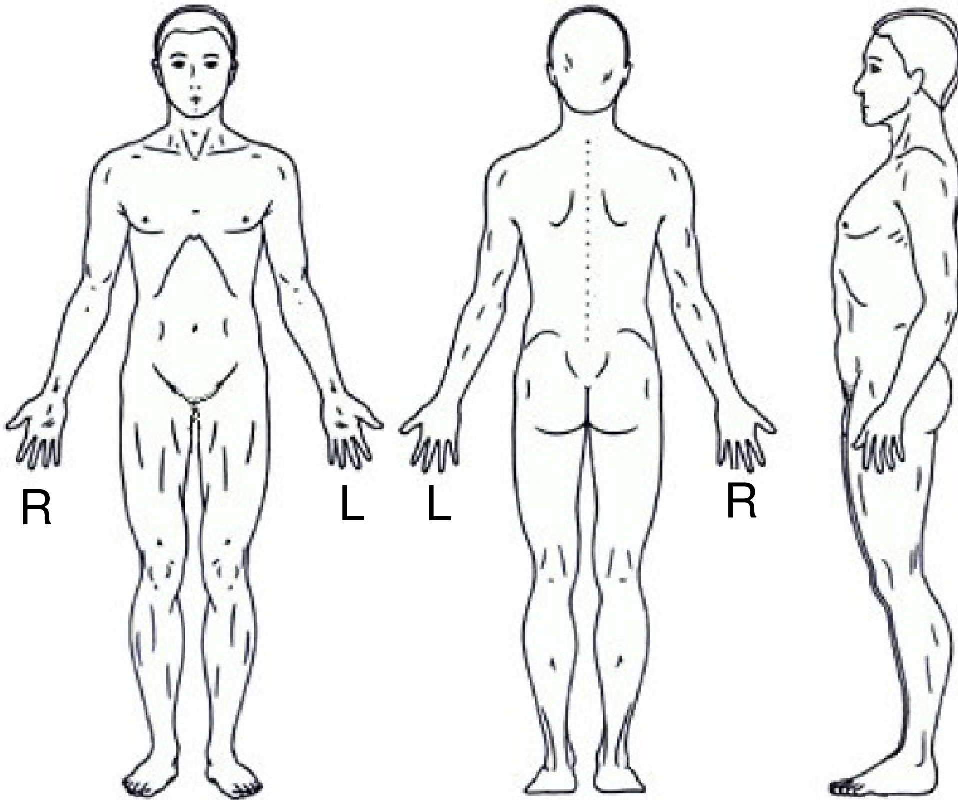
If so, whom?____

Have you received any medical tests for this conditions (X-Rays, blood tests, etc)? ☐ No ☐ Yes ______________

Other health problems you may have and would like us to address: ______________________________

Please draw location of your presenting complaint on the body outlines below

Sharp/Stabbing	Numbness	Burning	Aching	Pins/Needle	Other ________
/ / / / / / / / / / / / / / /	O O O O O O O	X X X X X X X	^ ^ ^ ^ ^ ^ ^ ^	....	= = = = = = = = = = = = = =



Please mark on the level of your pain on the scale above

Is there anything else you would like us to know that may help us with your visit? ______________________________
____
____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature ______________________________ **Date**______________________