AMBERWOOD TERRACE
CHIROPRACTIC

663 County Road 17, Suite 3
Elkhart, IN 46516

NEW PATIENT INTAKE FORM

Please fill out the following pages completely and leave no questions unanswered. All of the information will give us the best representation of different stressors that you have accumulated through your life, whether it be physical, chemical or emotional. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name _____ DOB: _____ Today's Date: _____

Address (Street)_____(City, State, Zip) _____

Home Phone: _____ Cell Phone: _____

SS#_____ Email Address: _____ Sex: ☐ M ☐ F

How did you hear about us? ☐I was a prior patient ☐Internet ☐Advertising

☐ Family/Friends (please provide name) _____ ☐Another Provider _____

Do you have ANY Medicare coverage? ☐ YES ☐ NO **Please provide these cards to ATC.**

Marital Status: ☐ M ☐ S ☐ W ☐ D Spouse's Name: _____

Emergency Contact: _____ Phone: _____

What is your occupation? _____

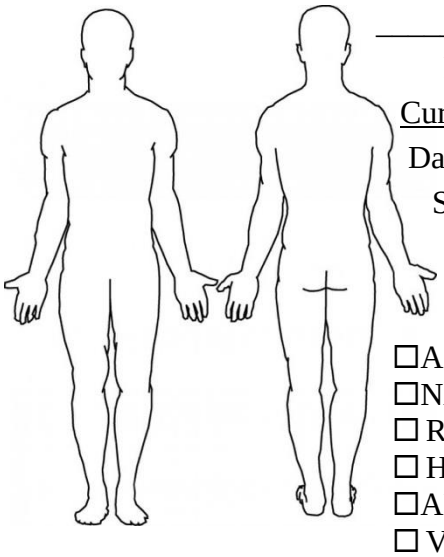
Please describe your work activities: _____

_____

Current Health Condition:

Chief Complaint (Why are you here today and how did you injure yourself?): _____

_____



_____

Please mark on the image the areas affected.

Current Symptoms: ☐ PAIN ☐ STIFFNESS ☐ NUMBNESS ☐ WEAKNESS

Date of Onset: _____ Date Symptoms Worsened: _____

Symptoms worse in the: ☐ MORNING ☐ AFTERNOON ☐ NIGHT

☐W/ACTIVITY ☐ CONSTANT ☐ INTERMITTENT

Associated signs & symptoms: ☐ BLURRED VISION ☐ HEADACHES
☐ACHES ☐ STIFFNESS ☐ DEPRESSION ☐IRRITABLE/MOOD SWINGS
☐NAUSEA ☐DIZZINESS ☐ NUMBNESS ☐ TINGLILNG
☐ RINGING IN EARS ☐ COLD LIMB ☐ FATIGUE ☐ FEVER
☐ HEARTBURN ☐ MUSCLE SPASM ☐ PALE BLUISH SKIN
☐ANXIETY ☐ RUNNY NOSE ☐ SWEATING ☐ SWELLING
☐ VOMITING ☐ WEAKNESS

Since condition has begun, has anything helped you? If yes, what? _____

On a scale of 0-10 (10 being the worst), what is the level of impairment due to symptoms (resting)? _____

On a scale of 0-10 (10 being the worst), what is the level of impairment due to symptoms (w/activity)? _____

Previous Treatment:

Previous Chiropractic Care? ☐ YES ☐ NO If yes, who? _____

Have you seen other doctors for this condition? ☐ YES ☐ NO If yes, who? _____

Are you currently taking any prescriptions medications? ☐ YES ☐ NO If yes, please list.

_____

_____

Complete Health History:

EYE/VISION: ☐ I DENY ANY EYE/ VISION ISSUE(S)	☐ **BLINDNESS** ☐ **TEARING** ☐ **CATARACTS** ☐ **ITCHING** ☐ **WEAR GLASSES/CONTACTS** ☐ **GLAUCOMA**
NERVOUS SYSTEM: ☐ I DENY ANY NERVOUS SYSTEM ISSUE(S)	☐ **DIZZINESS** ☐ **LOSS OF MEMORY** ☐ **LOSS OF CONSCIOUSNESS** ☐ **NUMBNESS** ☐ **SLEEP DISTURBANCE** ☐ **STROKES** ☐ **FACIAL WEAKNESS** ☐ **LIMB WEAKNESS** ☐ **HEADACHES** ☐ **SEIZURES** ☐ **UNSTEADINESS OF GAIT** ☐ **TREMORS**
EARS, NOSE AND THROAT: ☐ I DENY ANY E/N/T ISSUE(S)	☐ **BLEEDING** ☐ **DISCHARGE** ☐ **SNORING** ☐ **LOSS OF SMELL** ☐ **FREQUENT SORE THROATS** ☐ **SINUS INFECTIONS** ☐ **CONGESTION** ☐ **EAR INFECTIONS** ☐ **TINNITUS** ☐ **DIFFICULTY SWALLOWING** ☐ **TMJ PROBLEMS**
CARDIOVASCULAR: ☐ I DENY ANY CARDIOVASCULAR ISSUE(S)	☐**CHEST PAIN** ☐ **LEG PAIN OR ACHINESS** ☐ **HEART MURMUR** ☐ **ORTHOPNEA (DIFFICULTY BREATHING LYING DOWN)** ☐ **SWELLING OF LEGS** ☐ **ULCERS** ☐ **VARICOSE VEINS** ☐ **WAKING AT NIGHT SHORT OF BREATH** ☐**PALPITATIONS**
RESPIRATION: ☐ I DENY ANY RESPIRATORY ISSUE(S)	☐ **ASTHMA** ☐ **COUGHING UP BLOOD** ☐ **COUGH** ☐ **WHEEZING** ☐ **SPUTUM PRODUCTION** ☐ **SHORTNESS OF BREATH**
GASTOINTESTINAL: ☐ I DENY ANY GASTROINTESTINAL ISSUE(S)	☐ **ABDOMINAL PAIN** ☐ **DIARRHEA** ☐ **HEARTBURN** ☐ **JAUNDICE** ☐ **INDIGESTION** ☐ **CONSTIPATION** ☐ **RECTAL BLEEDING** ☐ **ABNORMAL STOOL** ☐ **VOMITING** ☐ **HEMORRHOIDS**
FEMALE: ☐ **I** DENY ANY FEMALE ISSUE(S)	☐ **BIRTH CONTROL** ☐ **BREAST LUMP** ☐ **CRAMPS** ☐ **HORMONE THERAPY** ☐ **IRREGULAR MENSTRUATION** ☐ **BURNING URINATION** ☐ **VAGINAL DISCHARGE**
MALE: ☐ I DENY ANY MALE ISSUE(S)	☐ **BURNING URINATION** ☐ **ERECTILE DYSFUNCTION** ☐ **IRREGULAR URINATION** ☐ **HESITANCY/DRIBBLING** ☐ **PROSTATE PROBLEMS**
ENDOCRINE: ☐ I DENY ANY ENDOCRINE ISSUE(S)	☐ **COLD INTOLERANCE** ☐ **EXCESSIVE APPETITE** ☐ **DIABETES** ☐ **EXCESSIVE THIRST** ☐ **HAIR LOSS** ☐ **HEAT INTOLERANCE** ☐ **VOICE CHANGES** ☐ **UNUSUAL HAIR GROWTH** ☐ **GOITER** ☐ **EXCESSIVE HUNGER**
SKIN: ☐ I DENY ANY SKIN ISSUE(S)	☐ **CHANGES IN NAIL TEXTURE** ☐ **CHANGES IN SKIN COLOR** ☐ **HAIR LOSS** ☐ **HAIR GROWTH** ☐ **HIVES** ☐ **ITCHINIG** ☐ **RASH** ☐ **SKIN LESIONS/ULCERS** ☐ **VARICOSITIES** ☐ **NUMBNESS, TINGLING, OR PRICKLING**
PSYCHOLOGIC: ☐ I DENY ANY PSYCHOLOGICAL ISSUE(S)	☐ **ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE)** ☐ **ANXIETY** ☐ **BIPOLAR DISORDER** ☐ **CONVULSIONS** ☐ **CONFUSION** ☐ **DEPRESSION** ☐ **INSOMNIA** ☐ **MOOD CHANGE(S)** ☐ **MEMORY LOSS**
ALLERGY: ☐ I DENY ANY ALLERGY ISSUE(S)	☐ **ANAPHYLAXIS** ☐ **ITCHING** ☐ **FOOD INTOLERANCE** ☐ **SNEEZING** ☐**NASAL CONGESTION**
HEMATOLOGY: ☐ I DENY ANY HEMATOLOGY ISSUE(S)	☐ **ANEMIA** ☐ **BLOOD CLOTTING** ☐ **BRUISES EASILY** ☐ **BLEEDING** ☐ **BLOOD TRANSFUSION(S)** ☐ **FATIGUE** ☐ **LYMPH NODE SWELLING**

Past Health History:

Childhood Illness: ☐ I deny any childhood illness(es) ☐ Other _____

☐ Spina Bifida ☐ Headaches ☐ Hepatitis ☐ HIV ☐ Measles ☐ Mumps ☐ Chicken Pox ☐ ADD

☐ Anemia ☐ Diabetes ☐ Ear Infections ☐ Eczema ☐ Allergies ☐ Asthma ☐ Bed Wetting ☐ Cerebral Palsy

Adult Illness: ☐ I deny any adult illness(es) ☐ Other _____

☐ Alzheimer's ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Measles ☐ Cancer ☐ Crohns ☐ CRPS

☐ Cystic Kidney Disease ☐ Depression ☐ Diabetes ☐ Emphysema ☐ HIV ☐ Hypertension ☐ Liver Disease ☐ Lung Disease ☐ Lupus ☐ MS ☐ Parkinson's ☐ Pleurisy ☐ Pneumonia ☐ Scoliosis

☐ Shingles ☐ STD's ☐ Thyroid Problems ☐ Vertigo

Immunizations: ☐ I deny any immunizations

☐ Diphtheria, Tetanus & Pertussis ☐ TB ☐ Chicken Pox ☐ Hepatitis A ☐ Hepatitis B

☐ Hepatitis C ☐ Influenza ☐ Polio ☐ Measles, Mumps & Rubella ☐ Pneumococcal ☐ Small Pox ☐ Whooping Cough ☐ COVID

HAVE YOU HAD ANY SURGERIES? ____ IF YES, PLEASE LIST. _____
PLEASE LIST ANY PREVIOUS INJURIES: _____
PLEASE LIST ANY NON-DRUG ALLERGIES: _____
HAVE YOU EVER BEEN PREGNANT? _____

FAMILY HISTORY ☐NONE	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	CHILD
CANCER							
HEART							
DIABETES							
KIDNEY							
AUTOIMMUNE							
HEREDITARY							
PSYCHIATRIC							
OTHER							

Social Health:

HOW OFTEN DO YOU USE TOBACCO? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY
HOW OFTEN DO YOU DRINK ALCOHOL? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY
HOW OFTEN DO YOU USE ILLICIT DRUGS? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY
HOW OFTEN DO YOU EXERCISE? ☐NEVER ☐1-2 DAYS/WEEK ☐3-4 DAYS/WEEK ☐5-7 DAYS/WEEK
HOW WOULD YOU DESCIRBE YOUR DIET? ☐POOR ☐ADEQUATE ☐GOOD ☐EXCELLENT
HOW WOULD YOU DESCRIBE YOUR SLEEP QUALITY? ☐POOR ☐ADEQUATE ☐GOOD ☐EXCELLENT
WHAT POSITION DO YOU NORMALLY SLEEP IN? ☐BACK ☐STOMACH ☐LEFT SIDE ☐RIGHT SIDE
HOW WOULD YOU DESCRIBE YOUR DAILY STRESS LEVELS? ☐NONE ☐MILD ☐MODERATE ☐EXCESSIVE
PLEASE LIST ANY ATHLETIC PARTICIPATION OR HOBBIES: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____