Chiro Health Pro LLC
Dr. Martin Petrovic, DC
chirohealthpro.com

ChirohealthPRO

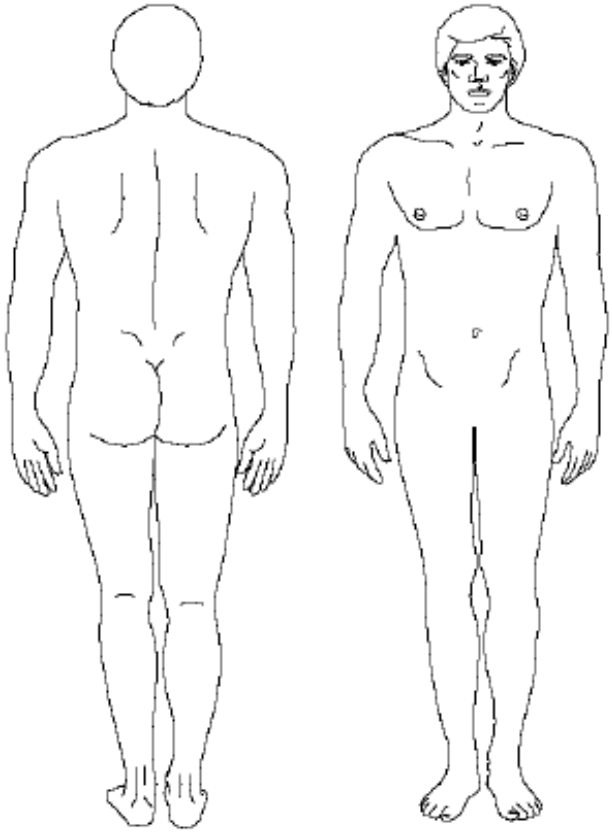
Mobile Practice
Portland, OR 97230
503-809-0800

Patient Initial Intake

Patient Name: _____ DOB: _____ Date: _____

Describe your symptoms: _____
_____
_____
_____

Indicate the location of your symptoms:



Describe any activities affected by your symptoms:
_____
_____

When did your symptoms begin? _____
_____

Are you symptoms getting worse? ☐ No ☐ Yes
Does it keep you from working? ☐ No ☐ Yes
Does it keep you from sleeping? ☐ No ☐ Yes

Have you seen a chiropractor before? ☐ No ☐ Yes
Are you under the care of a physician? ☐ No ☐ Yes
Name of physician: _____

Please list current medications and reasons for taking them:
_____
_____

Have you ever experienced:	No	Yes	If yes, briefly explain:
☐ broken bone	☐	☐	_____
☐ hospitalization/surgery	☐	☐	_____
☐ strains/sprains	☐	☐	_____
☐ fallen/struck unconscious	☐	☐	_____
☐ auto collision/work injury	☐	☐	_____

Please list any other health conditions (10 years): _____
_____
_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/day _____
☐ Heavy	☐ Heavy Labor	☐ Stress level	Reason _____

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Review of Systems

Patient Name: _____ DOB: _____ Date: _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please indicate all CURRENT or PAST conditions. To be responsible for your case, we need your complete health history.

C = Current problem P = Past problem

C	P	Muscle / Joint
☐	☐	Neck pain, stiffness
☐	☐	Pain b/t shoulders
☐	☐	Low back pain
☐	☐	Sciatica
☐	☐	Painful tailbone
☐	☐	Poor posture
☐	☐	Spinal curvature
☐	☐	Foot trouble
☐	☐	Swollen joints
☐	☐	Bursitis

C	P	Pain
☐	☐	Headache
☐	☐	Eye
☐	☐	Ear
☐	☐	Abdomen
☐	☐	Chest
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Elbows
☐	☐	Forearm
☐	☐	Hand
☐	☐	Hips
☐	☐	Thigh
☐	☐	Knee
☐	☐	Shin
☐	☐	Ankle
☐	☐	Feet

C	P	Numbness
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Forearm
☐	☐	Thigh
☐	☐	Shin / calf
☐	☐	Feet

C	P	General
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Concussion
☐	☐	Allergy
☐	☐	Skin rash
☐	☐	Enlarged glands

C	P	Cardiovascular
☐	☐	Hardened arteries
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Pain over heart
☐	☐	Poor circulation
☐	☐	Rapid heartbeat
☐	☐	Slow heartbeat
☐	☐	Swelling of ankles

C	P	Gastrointestinal
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Vomiting

C	P	Genitourinary
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Lose bladder control
☐	☐	Kidney infection
☐	☐	Painful urination
☐	☐	Prostate trouble

C	P	WOMEN ONLY:
☐	☐	Congested breasts
☐	☐	Lumps in breast
☐	☐	Menstrual pain
☐	☐	Irregular cycle
☐	☐	Excessive flow
☐	☐	Hot flashes
☐	☐	Menopause

C	P	Respiratory
☐	☐	Chronic cough
☐	☐	Difficult breathing
☐	☐	Spit up blood

Check any conditions you have presently OR have had in the past:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Pacemaker (or other medical implant): ☐ No ☐ Yes **Pregnant**: ☐ No ☐ Yes ☐ Planning

Please list any family history of serious illness (i.e. heart disease, stroke, cancer, diabetes):

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

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New Patient Registration

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Social Security #: _____ - _____ - _____

Address: _____

Primary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

Secondary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

E-mail: _____ ☐ opt-in ☐ opt-out

Employer: _____ Occupation: _____

Primary Physician's Name: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Address: _____

Next of Kin: ☐ same as emergency ☐ other: _____

Who may we thank for referring you? _____

Payment information

☐ I will pay my balance in full at time of service
☐ I prefer to make payment arrangements prior to services being rendered
☐ I intend to bill insurance (we provide superbill for you to submit for reimbursement):

Name of Insured _____ Relationship to Patient: _____

Insurance Company: _____ Claims Phone: (_____) _____ - _____

Claim #: _____ Representative name: _____

Date of collision/work injury: _____ Other contact info: _____

Patient/Guardian Signature: _____ Date: _____