13110 SE Sunnyside Rd.
Suite B
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o: 503-698-5866
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Dr. Zachary Taylor, DC

NEW PATIENT INTAKE FORM

Today's Date: _____/_____/_____ Name: ____

Address: ____

Age: _____ Date of Birth: _____/_____/_____ Gender: _________ Height: _____'_____" Weight: _____

Primary Phone: ________________________ Is this a cell phone? YES NO Work Phone: ______________________________

Occupation/Employer: _______________________________ Email : ____

Emergency Contact: ______________________ Relationship: ________________ Phone Number: __________________________

Insurance Company: __________________________ Member ID / Claim Number: _______________________________________

Primary Physician: _________________________ Location:____________________________ Phone: _______________________

How did you find this office: ____

HWC

What has brought you here today? ____

What do you need/want to be doing that your current condition is preventing you from?

____

How long do you think this will take?

☐ Today ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ I have no idea ☐ Other: ___________________________________

When did your symptoms begin?

☐ Today ☐ Days ago ☐ Weeks ago ☐ Months ago ☐ Years ago ☐ Date: ______/______/________

Was there a single traumatic event or mechanism of injury that caused your symptoms?

☐ No Yes (*describe it*): ____

Would you describe your symptoms as:

☐ Getting worse Getting better ☐ Holding / Maintaining

How do your symptoms respond to your average daily routine?

☐ Worst in the morning ☐ Worse as the day progresses ☐ All day, same level ☐ Worse with a motion/posture

How often do you experience your symptoms?

☐ >75% of the time ☐ >50% of the time ☐ >25% of the time ☐ <25% of the time ☐ Only if I move the wrong/right way

Please, describe what your symptoms feel like:

☐ Painful ☐ Tight ☐ Tingling / Prickly ☐ Electric ☐ Numbness ☐ Unstable ☐ Disturbing

☐ Dull ☐ Dull, but Sharp if I move the wrong/right way ☐ Sharp

☐ Other (*describe it*): ____

What is the <u>most intense pain</u> you have experienced from this issue <u>in the past week</u>?

No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable

As you are reading this page, how intense is your pain <u>right now</u>?

No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable

Doctor's initials in lieu of signature ___________________

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What makes your symptoms better?

☐ Rest ☐ Laying down ☐ Sitting ☐ Standing ☐ Walking ☐ Stretching ☐ Exercise ☐ Ice / Cold ☐ Hot Pack

☐ Heating Pad ☐ Nothing ☐ Other: ____________________

What makes your symptoms worse?

☐ Looking up ☐ Looking down ☐ Lifting ☐ Bending ☐ Standing ☐ Walking ☐ Sitting ☐ Reaching Overhead

☐ Computer use ☐ Laying down ☐ Coughing ☐ Sneezing ☐ Going to the bathroom ☐ Nothing

☐ Other: ____________________

Are your symptoms affecting your activities at home?

☐ No ☐ Yes (*how or what*): ____________________

Are your symptoms affecting your activities at work?

☐ No ☐ Yes (*how or what*): ____________________

What forms of treatment have you received for your current symptoms?

☐ None ☐ Hospital ☐ Urgent Care ☐ Medical Doctor ☐ Prescription Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Other: ____________________

Have you had X-Rays or other imaging for your current symptoms?

☐ No ☐ Yes (*what and where*): ____________________

HWC

Do you currently have a primary care MD?

☐ No ☐ Yes (*who and where*): ____________________

Have you ever been treated by a chiropractor before?

☐ No ☐ Yes (*who and when*): ____________________

Have you ever been hospitalized?

☐ No ☐ Yes (*why and when*): ____________________

____

Have you had any surgical procedures performed?

☐ No ☐ Yes (*why and when*): ____________________

____

Are you currently taking any vitamins or supplements?

☐ No ☐ Yes (*what kind, how much, how often*): ____________________

____

Are you currently taking any medications (prescription and over the counter)?

☐ No ☐ Yes (*what kind, how much, how often*): ____________________

____

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Do you smoke or vape?

☐ No ☐ Not anymore (*what kind, how much, how often*): ______

☐ Yes (*what kind, how much, how often*): ______

Do you drink/take anything that contains caffeine (*coffee, soda, energy drinks, etc*)?

☐ No ☐ Yes (*what kind, how much, how often*): ______

Do you have annual physicals?

☐ No ☐ Yes

Do you have regular dental check-ups?

☐ No ☐ Yes

In your family (*yourself, children, siblings, parents, and grandparents*), is there a history of:

Cancer (*who and type*): ______

Diabetes (*who and type*): ______

Heart disease (*who*): ______

High blood pressure (*who*): ______

Scoliosis (*who*): ______

In the past 6 months, have you experienced (*leave blank if not applicable*):

Headaches ☐ Yes (*describe*): ______

Irregular bowel movements ☐ Yes (*describe*): ______

Nausea ☐ Yes (*describe*): ______

Lightheadedness ☐ Yes (*describe*): ______

Shortness of breath ☐ Yes (*describe*): ______

Chest pain or tightness ☐ Yes (*describe*): ______

Fainting ☐ Yes (*describe*): ______

Lost time ☐ Yes (*describe*): ______

Visual changes ☐ Yes (*describe*): ______

Difficulty swallowing ☐ Yes (*describe*): ______

Hearing changes ☐ Yes (*describe*): ______

Ear pain ☐ Yes (*describe*): ______

Jaw pain ☐ Yes (*describe*): ______

Shoulder pain ☐ Yes (*describe*): ______

Mood irregularities ☐ Yes (*describe*): ______

Numbness or tingling sensation ☐ Yes (*describe*): ______

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