Victory Health, LLC Intake Form

Name____ **SS#** _____-_____-______

Address____________________________________**City**____________**St.** __**ZIP**__________

Home #______________________**Cell #** __________________ **Birthdate**_______________

Marital Status: (Circle) Single Married Widowed Divorced **Spouse Name**__________________

Employer______________________________ **Work #**_______________**Current Occupation**______________________

Have you ever been treated by a chiropractor? _____**Who referred you to this office?** _____________

Do you exercise?___ **Are you pregnant?**____ **How did you choose us?** Phone Book Friend Sign Family Internet Doctor

Emergency Contact______________**Phone #**_____________ **Is it ok to discuss your medical care with them?** Yes No

What is your present pain level (1-10) (10 being worst)?_____________________

What is the worst your pain has been (1-10) (10 being worst)___________

What makes the pain worse?___________________________

What is the lowest pain level (1-10) (10 being worst)?_____________________

Did your pain come sudden or gradual?__________________

How long have you been hurting?_______________________

How do you describe the pain?__________________________

What makes the pain better?___________________________

What treatments have you done related to your chief complaint? (medication, therapy, etc.)_____________________

Who is your Primary Medical Doctor? ____

Which pharmacy do you use?____

What medications are you taking for your chief complaint?____

Have you had any tests done related to your chief complaint? (MRI, X-rays, etc.) _______________________________

Do you smoke? _______ **Do you consume alcohol?**____________ **Do you use illicit drugs?**_______________________

Surgeries

Angioplasty	Arthroscopy	Appendectomy	Cardiac Catheter
Gallbladder	Colostomy	Coronary Artery Bypass	Gastric Bypass
Hand or Foot Surgery	Heart Valve	Hysterectomy	Intestinal Surgery
Laminectomy	Laparotomy	Lung Surgery	Mastectomy
Knee	Shoulder	Pacemaker	Radiation Therapy
Skin Lesion Excisions	Spinal Fusion	Tonsillectomy	Thyroid
Hip	Vascular Surgery	Other__________________________________	

Patient Name ____

Patient Date of Birth__________________________________

What pharmacy do you use? ____________________________

What Medications Are You Currently Taking?

Medications	Dosage	Frequency (i.e. 2 times a day)

☐ NONE

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Do you have any Medication Allergies?

Medications	Reaction	Onset date

☐ NONE

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____
____
____
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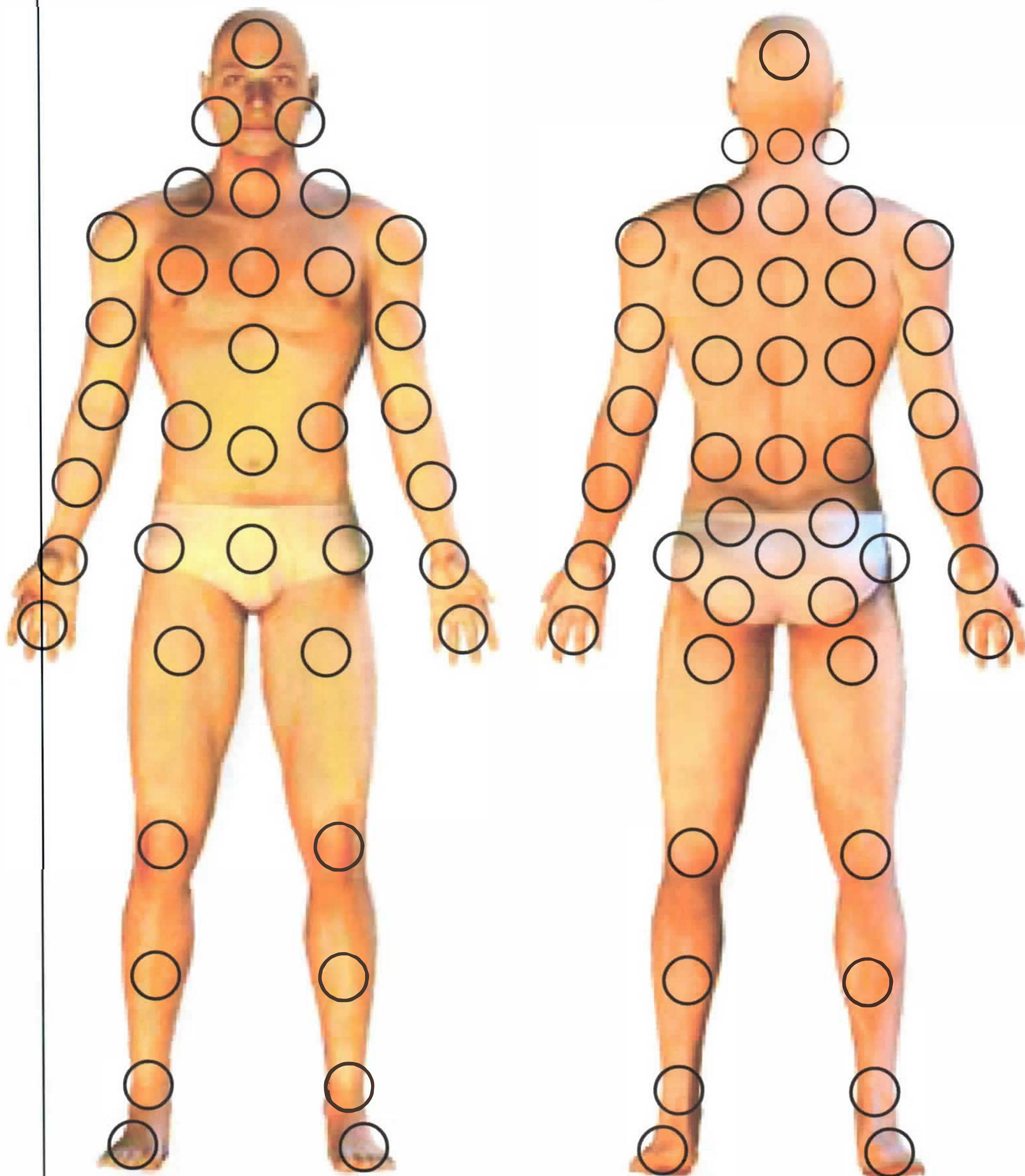

In the circles please mark the following:
S=Stabbing Pain, P=Pins&Needles,
N=Numbness, B=Burning, A=Ache

Your Health History Checklist

Chronic Conditions (longterm)

Allergy	☐ Food ☐ Latex ☐ Anesthetics
Blood & Lymphatic	☐ Anemia ☐ Bleeding Disorders ☐ Immune deficiency ☐ Thrombosis ☐ Need for anticoagulants
Cancer	☐ List type and organ ____________________
Cardiovascular	☐ Hypertension (high blood pressure) Coronary artery disease ☐ Congestive heart failure ☐ Valvular disease ☐ Atrial fibrillation ☐ Aortic aneurysm ☐ Aortic dissection Heart Attack
Ear/Nose/Throat	☐ Chronic Sinusitis ☐ Hearing Impairment ☐ Tinnitus (ringing in ears) ☐ Vertigo (dizziness) ☐ Upper airway allergies (allergic rhinitis) ☐ Chronic laryngeal conditions
Endocrine	☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism
Eye/Vision	☐ Glaucoma ☐ Cataract ☐ Macular degeneration ☐ Color blindness ☐ Ocular misalignment ☐ Retinal abnormality (e.g. detachment, degeneration) ☐ Amblyopia (lazy eye)
Female Reproductive & Breast	☐ Cancer ☐ Endometriosis ☐ Ovarian cysts
Gastrointestinal	☐ Peptic ulcer ☐ Reflux esophagitis ☐ Colitis
HIV/AIDS Opportunistic infections	☐ HIV year diagnosed ______
Kidney & Urologic (urinary tract) **Disease**	☐ Kidney Failure ☐ Chronic infections ☐ Kidney stones ☐ Glomerulonepritis ☐ Nephrotic syndrome ☐ Enlarged Prostate ☐ Chronic prostatitis ☐ Ischemic bowel disease
Liver	☐ Cirrhosis ☐ Hepatitis Type A B C

Your Health History Checklist

Chronic Conditions (long term)

Musculoskeletal / Joint	☐ Degenerative arthritis ☐ Rheumatoid arthritis ☐ Lupus ☐ Lyme arthritis ☐ Gout ☐ Osteoporosis
Neurologic	☐ Stroke ☐ Aneurysm ☐ Parkinson's disease ☐ Multiple sclerosis ☐ Headaches ☐ Seizure disorder (epilepsy) ☐ Alzheimer's / dementia ☐ Peripheral neuropathy ☐ Spina bifida
Psychiatric	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Pre-menstrual syndrome (PMS)
Respiratory	☐ Asthma ☐ COPD ☐ Pulmonary embolus (blood clot to lung) ☐ Collapsed lung ☐ Tuberculosis
Skin	☐ Dermatitis / Eczema ☐ Psoriasis ☐ Skin cancer(s)
Sleep Disorders	☐ Sleep apnea ☐ Narcolepsy ☐ Cataplexy
Other Chronic Conditions	☐ Chronic Pain ☐ Other ______________________ Fibromyalgia

Family Health History
(please list pertinent illnesses/diseases)

Mother____

Father____

Sister____

Brother____