Dr. Rachael Bryant

Living Well Chiropractic

of Penn Hills

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Patient Intake Form:

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name _____

Date of Birth: _____ □ male □female

Address: _____

_____

Marital status __Sing __ Mar __ Wid __ Div __ Sep __ Part

Phone #: home: _____ work: _____

E-mail address: _____

Occupation: _____

Employer: _____

Emergency Contact: _____

Check if you have or have ever had any of the following:

General
- □ Allergies
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Headaches
- □ Loss of sleep
- □ Mental illness
- □ Nervousness
- □ Tremors
- □ Weight loss / gain

Muscle / Joint
- □ Arthritis / rheumatism
- □ Bursitis
- □ Foot trouble
- □ Muscle weakness
- □ Low back pain
- □ Neck pain
- □ Mid back pain
- □ Joint pain

Skin
- □ Boils
- □ Bruise easily
- □ Dryness
- □ Hives or allergies
- □ Itching
- □ Rash
- □ Varicose veins

Eye, Ear, Nose & Throat
- □ Colds
- □ Deafness
- □ Ear ache
- □ Eye pain
- □ Gum trouble
- □ Hoarseness
- □ Nasal obstruction
- □ Nose bleeds
- □ Ringing of the ears
- □ Sinus infection
- □ Sore throat
- □ Tonsilitis
- □ Vision problems

Gastrointestinal
- □ Abdominal pain
- □ Bloody or tarry stool
- □ Colitis / Crohn's
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficult digestion
- □ Diverticulosis
- □ Bloated abdomen
- □ Excessive hunger
- □ Gallbladder trouble
- □ Hernia
- □ Hemorrhoids
- □ Intestinal worms
- □ Jaundice
- □ Liver trouble
- □ Nausea
- □ Painful defication
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting
- □ Vomiting of blood

Genitourinary
- □ Bed-wetting
- □ Bladder infection
- □ Blood in urine
- □ Kidney infection
- □ Kidney stones
- □ Prostate trouble
- □ Pus in urine
- □ Stress incontinence
- □ Urination
  - □ Overnight more than twice
  - □ More than 8x in 24hrs
  - □ Decreased flow/force
  - □ Painful urination
  - □ Urgency to urinate

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Hardening of the arteries
- □ Irregular pulse
- □ Pain over heart
- □ Palpitation
- □ Poor circulation
- □ Rapid heart beat
- □ Slow heart beat
- □ Swelling of ankles

Respiratory
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Hay fever
- □ Shortness of breath
- □ Spitting up phlegm / blood
- □ Wheezing

Women only
- □ Congested breasts
- □ Hot flashes
- □ Lumps in breast
- □ Menopause
- □ Vaginal discharge

Menstrual flow
□ Reg. □ Irreg. □ Pain / cramps

Days of flow: ____

Lengths of cycle: _____

Date - 1st day last period: _____

Are you pregnant? □ yes, □ no

If yes, how many months? _____

How many children do you have? ____

Birth control method: _____

Date of last PAP test: _____
□ normal, □ abnormal

Date of last mammogram: _____
□ normal, □ abnormal

Conditions
- □ Alcoholism
- □ Anemia
- □ Appendicitis
- □ Arteriosclerosis
- □ Asthma
- □ Bronchitis
- □ Cancer
- □ Chicken pox
- □ Cold sores□ Diabetes
- □ Eczema
- □ Edema
- □ Emphysema
- □ Epilepsy
- □ Goiter
- □ Gout
- □ Heart burn
- □ Heart disease
- □ Hepatitis
- □ Herpes
- □ High cholesterol
- □ HIV/AIDS
- □ Influenza
- □ Malaria
- □ Measles
- □ Miscarriage
- □ Multiple sclerosis
- □ Mumps
- □ Numbness/tingling
- □ Pace maker
- □ Osteoporosis
- □ Pneumonia
- □ Polio
- □ Rheumatic fever
- □ Stroke
- □ Thyroid disease
- □ Tuberculosis
- □ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

_____

_____

Please describe the principal health problems for which you came to this office.

Give a brief detailed description of the problem you are currently experiencing:

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

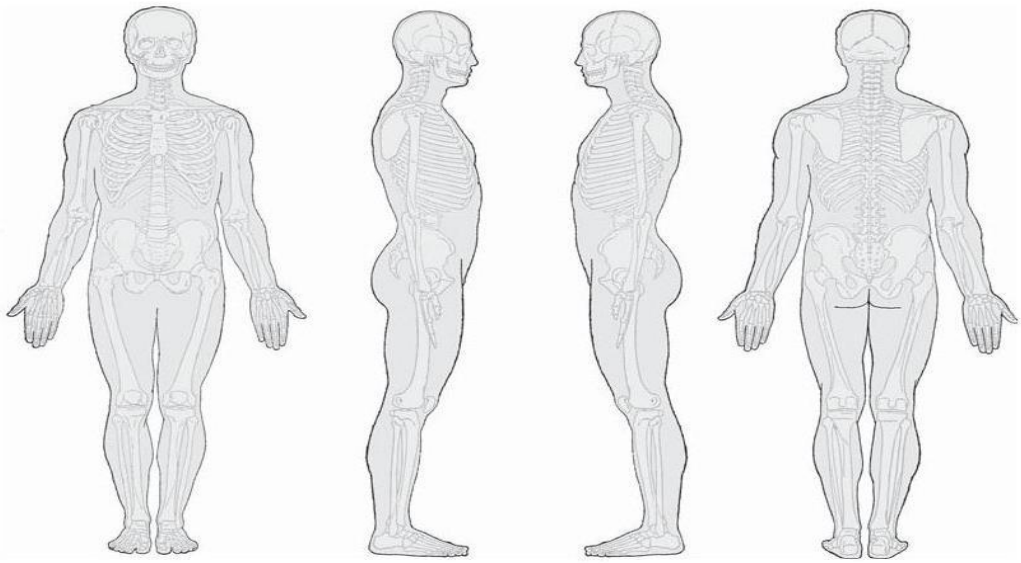
Where does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain
10
9
8
7
6
5
4
3
2
1
0
No Pain

Please mark you area(s) of pain on the figure below



Past Health History

Have you...	N	Y	Explain
…been hospitalized in the last 5 years?			
…had any mental disorders?			
…had any broken bones?			
…had any strains or sprains?			
…ever used orthotics?			
Do you take minerals, herbs or vitamins?			
Have you ever had a DOT exam?			
How old is your mattress?			
When was your last physical exam?			
How is most of your day spent?			

Habits

	none	light	mod.	heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Soft Drinks				
Salty foods				
Water				
Sugar				

Family History

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism
□ Anemia
□ Arteriosclerosis
□ Arthritis
□ Asthma
□ Bleed easily
□ Cancer
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Heart disease Heart disease
□ High blood pressure
□ High cholesterol
□ Multiple sclerosis
□ Osteoporosis
□ Stroke
□Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

_____

_____