



**GONSTEAD CHIROPRACTIC**  
**OR**  
**STANGL CHIROPRACTIC**  
 431 E. Clairemont Avenue  
 Eau Claire, WI 54701  
 715-832-2223

**NEW PATIENT INTAKE**

Date \_\_\_/\_\_\_/\_\_\_  
 Name (first) \_\_\_\_\_ (M) \_\_\_ (Last) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: Male Female  
 Current Email \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Marital Status  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED  
 Spouse's Name \_\_\_\_\_  
 Children  NO  YES NAME(S) \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Who referred you to our office?  
 INSURANCE  WEBSITE  TV  NEWSPAPER  POSTCARD  HEALTH PRESENTATION  
 FRIEND/FAMILY \_\_\_\_\_  OTHER \_\_\_\_\_

**RACE/ETHNICITY**

**Ethnicity**  Hispanic/Latino  
 NOT Hispanic/Latino

**Race**  Caucasian/White  
 African American/Black  
 Asian  
 Native American  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_

**SOCIAL HISTORY**

**Work Activities**  SIT  STAND  COMPUTER  LIFT  TWIST  BEND  REPETITION  
**Exercise**  FREQUENT/DAILY  OFTEN/3-4X WK  OCCASIONAL/1X WK  
 SELDOM  NEVER  
 Current exercise includes \_\_\_\_\_  
**Diet**  GREAT  ADEQUATE  OKAY  POOR  
**Smoking Status**  NEVER SMOKER  DAILY SMOKER  OCCASIONAL SMOKER  QUIT  
 Do you use non-smoking tobacco products?  Yes  No  
**Alcohol Status**  FREQUENT CONSUMPTION  OCCASIONAL CONSUMPTION  NEVER  
 I CONSUME  BEER  SPIRITS/LIQUOR  WINE/CHAMPAGNE  
**Caffeine Status**  FREQUENT CONSUMPTION  OCCASIONAL CONSUMPTION  NEVER

**Women Only**

Are you pregnant  Yes  No  
 Due date \_\_\_\_\_  
 Last cycle \_\_\_\_\_

Miscarriage  Yes  No  
 Menopause  Yes  No

Perform Self  
 Breast Exams  Yes  No

Current PAP  Yes  No

Current  
 Mammogram  Yes  No

**SELF AND FAMILY HEALTH HISTORY (check box where it applies)**

Condition	SELF	FATHER	MOTHER	SIBLING	GRAND PARENT
Heart Disease					
Hypertension					
High Cholesterol					
Stroke					
Aneurysm					
Diabetes					
Cancer/Tumors					
Epilepsy/Seizure					
Multiple Sclerosis					
Osteopenia/porosis					

**SURGICAL HISTORY**

DATE	SURGERY

**ACCIDENT/INJURY/FRACTURE HISTORY**

DATE	ACCIDENT/INJURY/FRACTURE

**PLEASE LIST THE FOLLOWING WHEN APPROPRIATE;**

- Previous Chiropractic Care     YES    NO; if yes last visit date? \_\_\_\_\_
  - Doctor of Chiropractic Name/Location \_\_\_\_\_
- Current Health Care Providers
  - Medical/Alternative \_\_\_\_\_
    - Reason(s) \_\_\_\_\_
  - Medical/Alternative \_\_\_\_\_
    - Reason(s) \_\_\_\_\_
  - Medical/Alternative \_\_\_\_\_
    - Reason(s) \_\_\_\_\_
  - Medical/Alternative \_\_\_\_\_
    - Reason(s) \_\_\_\_\_
  - Medical/Alternative \_\_\_\_\_
    - Reason(s) \_\_\_\_\_

Have you had X-rays or other specialized imaging (MRI, CT, etc) within the past 2 years?    YES    NO

CURRENT MEDICATIONS (Rx or OTC), VITAMINS, HERBS AND SUPPLEMENTS				
STARTED	NAME	DOSE	FREQUENCY	PRESCRIBED BY

ALLERGIES AND SENSITIVITIES		
TYPE	CAUSE	REACTION
Medication Environment Food		
Medication Environment Food		
Medication Environment Food		
Medication Environment Food		
Medication Environment Food		
Medication Environment Food		
Medication Environment Food		

\_\_\_\_\_  
PATIENT NAME (PRINT)

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**REVIEW OF SYSTEMS – Check  if PAST problem; circle  if CURRENT problem**

**GENERAL**

- Recent weight gain
- Recent weight loss
- Loss of strength
- Exercise intolerant
- Difficulty with ADLs

**SKIN/BREAST**

- Rash/Itching/Pigmentation
- Moist/Dry/Texture
- Change in hair growth/loss
- Nail Changes
- Breast lump/tenderness
- Breast swelling/discharge

**ENT**

- Headaches/Migraines
- Vertigo/Dizziness
- Vision
- Nosebleeds
- Colds/Congestion
- Dental Issues/TMJ
- Throat tenderness/masses

**CARDIOVASCULAR**

- Chest Pain
- Palpations
- Syncope
- Shortness of breath on exertion
- Sleep apnea

**HYPERTENSION**

- Hypertension
- Heart murmur
- Varicosities

**RESPIRATORY**

- Shortness of breath
- Pain/wheezing
- Cough
- Infections
- Fever/night sweats

**MUSCULOSKELETAL**

- Pain/swelling
- Muscular weakness
- Limitation of motion
- Arthritis

**GASTROINTESTINAL**

- Appetite increase/decrease
- Indigestion
- Abdominal pain
- Heartburn
- Nausea/vomiting
- Constipation/diarrhea
- Abnormal stools
- Hemorrhoids
- Change in bowel habits

**GENITOURINARY**

- Urgency/frequency
- Difficulty urinating
- Bed wetting
- Unusual color/smell urine
- Infections
- Pain on urination
- Libido
- Bleeding/discharge
- Venereal disease
- Cycle irregularities-female

**NEUROLOGIC**

- Convulsions
- Paralyzes
- Tremors
- Incoordination
- Numbness/tingling
- Memory
- Speech

**PSYCHIATRIC**

- Nervousness
- Anxiety
- Depression
- Unusual perceptions
- Previous psychiatric care

**IMMUNOLOGIC/LYMPH/ENDOCRINE**

- Anemia
- Bleeding issues
- Lymph node large/tender
- Frequent thirst/hunger
- Heat/cold intolerant
- Hormone therapy

**HISTORY OF PRESENT COMPLAINT**

Is your present complaint due to any of the following?  AUTO ACCIDENT  WORK INJURY  PERSONAL INJURY  NO  
 Have you had any recent accidents, falls, or injuries?  YES  NO  
 Have you had any recent hospitalizations or new diagnoses?  YES  NO  
 Have you had any recent major life events?  YES  NO

**PLEASE DESCRIBE YOUR CURRENT COMPLAINT(S) AND MARK THE DIAGRAM WHERE YOUR PAIN/SYMPTOMS ARE EXPERIENCED.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When did your complaint start? \_\_\_\_\_

Was pain/symptom onset  GRADUAL  SUDDEN

Is the pain/symptom getting  BETTER  WORSE  NO CHANGE

What caused/contributed/provoked it? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

**Check any box that describes the quality of the symptoms you experience**

- ACHE  SORE  TIGHT  BURN  PINCH  SHARP  STAB  STING  STIFF  CONSTRICT  CRAMP  NUMB  TINGLE  THROB

**Do/Are your pain/symptom(s)**  LOCALIZED/STAY IN ONE SPOT  RADIATE/TRAVEL  GENERALIZED/REGIONAL

**How severe is/are your pain/symptoms?**

ADL = Activities of Daily Living

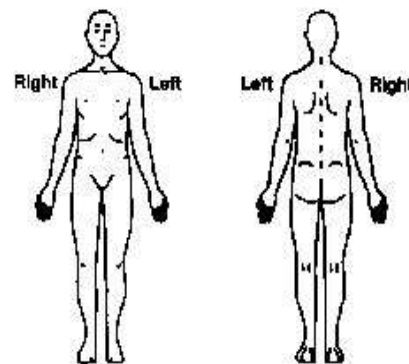
- MINIMAL (NO IMPAIRMENT)  SLIGHT (SOME IMPAIRMENT)  MODERATE (ADLS DIFFICULT/PAINFUL)  MARKED (PRECLUDE ACTIVITY)

**How frequent is/are your pain/symptoms during waking hours?**

- INTERMITTENT (0-25%)  OCCASIONAL (25-50%)  FREQUENT (50-75%)  CONSTANT (75-100%)

**Does your pain/symptoms interfere with or make activities of daily living difficult?**  Yes  No

If Yes;  SELF CARE  WORK DUTIES  CHILD CARE  HOUSEWORK  YARD WORK  EXERCISE  RECREATION  SOCIAL LIFE



Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_