Chiropractic Offices of Gonstead, Stangl & Arkowski, LLCs

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503 E. Clairemont Avenue ◆ Eau Claire, WI 54701 ◆ 715-832-2223

Date:

NEW PATIENT INTAKE			
Name (first) (M) (Last)			
Address	**City**	**State**	**Zip**
Phone (Home) (Cell) (Work)			
Date of Birth	**Age**	**Gender** ☐ Male ☐ Female	
Email Address			
Race ☐ Caucasian/White ☐ African American/Black ☐ Asian ☐ Native American ☐ Other			
Ethnicity ☐ Hispanic/Latino ☐ NOT Hispanic/Latino			
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed			
Spouse's Name			
Children ☐ YES ☐ NO name(s)			
Employer	**Occupation**		
Emergency Contact	**Phone**	**Relationship**	
How did you hear about our office? ☐ insurance ☐ medical provider ☐ website ☐ Facebook ☐ ad/event ☐ family/friend:			

SOCIAL HISTORY
Smoking Status ☐ Never Smoker ☐ Daily Smoker ☐ Occasional Smoker ☐ Former Smoker – quit date:
Do you use non-smoking tobacco products? ☐ NO ☐ YES
Alcohol Status ☐ None ☐ Casual ☐ Moderate ☐ Heavy ☐ Beer ☐ Wine ☐ Liquor
Caffeine Status ☐ None ☐ less than 3 drinks/day ☐ 3-6 drinks/day ☐ more than 6 drinks/day
Exercise ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims ☐ Weights ☐ Other:

FAMILY HISTORY - ☑ where applicable					
CONDITION	**SELF**	**FATHER**	**MOTHER**	**SIBLING**	**GRANDPARENT**
Aneurysm					
Cancer/Tumor					
Diabetes					
Epilepsy/Seizure					
Heart Disease					
High Cholesterol					
Hypertension					
Multiple Sclerosis					
Osteopenia/porosis					
Stroke					

PATIENT HISTORY				
DATE	**SURGERY - HOSPITALIZATIONS**		**DATE**	**ACCIDENT - ILLNESS - INJURY**

Patient Initials _____

PATIENT NAME	DATE

Previous Chiropractic Care ☐ NO ☐ YES Approximate Last Appointment:
Previous Doctor of Chiropractic Name/Location:

Current Health Care Provider(s)	Location(s)
Do you grant permission to contact these providers? ☐ NO ☐ YES Please initial here →	

Have you had radiology imaging within the past 2 years? ☐ NO ☐ YES		
☐ X-RAY	Region:	Date/Location:
☐ MRI ☐ CT	Region:	Date/Location:
☐ OTHER	Region:	Date/Location:

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

ALLERGIES AND SENSITIVITIES	REACTION

REVIEW OF SYSTEMS – Please circle C = current P = Past

GENERAL			**CARDIOVASCULAR**			**GASTROINTESTINAL**			**ENT**		
C	P	Weight Gain	C	P	Chest Pain	C	P	Abdominal Pain	C	P	Cold/Congested
C	P	Weight Loss	C	P	Heart Murmur	C	P	Abnormal Stool	C	P	Dizzy/Vertigo
SKIN/BREAST			C	P	Hypertension	C	P	Appetite ⇧⇩	C	P	Headache/Migraine
C	P	Breast lump/tender	C	P	Palpations	C	P	Change in bowel	C	P	Nosebleeds
C	P	Dry Skin/Texture	C	P	Sleep Apnea	C	P	Constipation	C	P	Throat tender/mass
C	P	Nail Changes	C	P	Shortness of breath	C	P	Diarrhea	C	P	Vision changes
C	P	Mole Changes	C	P	Syncope (fainting)	C	P	Heartburn	**PSYCHIATRIC**		
C	P	Rash/Itching	C	P	Varicosities	C	P	Hemorrhoids	C	P	ADD/ADHD
NEUROLOGIC			**RESPIRATORY**			C	P	Indigestion	C	P	Anxiety
C	P	Convulsions	C	P	Asthma	C	P	Nausea/Vomit	C	P	Depression
C	P	Incoordination	C	P	Cough	**GENITOURINARY**			C	P	Bipolar
C	P	Memory	C	P	COPD	C	P	Bed Wetting	**IMMUNE/LYMPH/ENDOCRINE**		
C	P	Neuropathy	C	P	Fever/night sweats	C	P	Bleeding/Discharge	C	P	Anemia
C	P	Numbness	C	P	Infections	C	P	Cycle Irregularities	C	P	Bleeding Issues
C	P	Paralysis	C	P	Pain/Wheezing	C	P	Difficulty urinating	C	P	Lymph node large/tender
C	P	Speech	C	P	Shortness of breath	C	P	Libido	C	P	Frequent thirst/hunger
C	P	Tingling	C	P	Pneumonia	C	P	Pain on Urination	C	P	Heat/cold intolerant
C	P	Tremors				C	P	Unusual color/smell Urine	C	P	Thyroid Issues
						C	P	Urgency/Frequency			

FEMALES	Are you currently pregnant ☐ NO ☐ YES Due Date:	History of previous miscarriage? ☐ NO ☐ YES
Menopause ☐NO ☐YES	Current PAP ☐NO ☐YES	Current Mammogram ☐NO ☐YES Regular self-breast exams ☐ NO ☐ YES

Patient Initials _____

PATIENT NAME	DATE

HISTORY OF PRESENT COMPLAINT
Are your present complaints due to any of the following: ☐ Auto Accident ☐ Work Injury ☐ Personal Injury ☐ No
Have you had any recent accidents, falls, or injuries? ☐ No ☐ Yes approximate date:
Have you had any recent hospitalizations or new diagnoses? ☐ No ☐ Yes
Have you had any recent major life events? ☐ No ☐ Yes

NECK ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	

HEADACHE/MIGRAINE ☐ No Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Describe location AND quality of symptoms:	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Daily ☐ Weekly ☐ Monthly ☐ Constant (75-100%)	

MIDBACK ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	

LOW BACK/HIP/PELVIS ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	
Check if you experience ☐ Upper extremity complaints ☐ Lower Extremity complaints ☐ Other Complaints:	

Patient Signature _____ Date _____