Health in Motion
Chiropractic & Wellness

New Patient Intake

PATIENT INFORMATION

Name: ________________________________ Birthday (M/D/Y): ___________ Age: _____ Gender: _________

Address: ____

Home Ph. #: ___________________ Cell: ___________________ Email: ________________________________

Marital status: _________________ # of Children: _____ Occupation: ___________________________________

Can Dr. Rausch use your email address to contact you concerning your care, newsletters and promotions? Y/N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer ☐ Newspaper

☐ Referral: _______________________ ☐ Other: ___________________________________

Name of:

MD/DO/PA: ____

DC/PT: ____

Emergency Contact:

Name:_________________________ Relationship:_______________________ Telephone:__________________

Are you currently under the care of another physician? Y/N

Physicians Name:______________________________ Telephone:_________________________________

For what condition?____

Treatment?____

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

Childhood Illnesses:

☐ ADHD	☐ atopic dermatitis	☐ allergies	☐ anemia
☐ Asthma	☐ bedwetting	☐ cerebral palsy	☐ chicken pox
☐ Crohn's	☐ depression	☐ diabetes	☐ ear infections
☐ Headaches	☐ hepatitis	☐ HIV	☐ measles
☐ Mumps	☐ psoriasis	☐ rash	☐ scoliosis
☐ Seizures	☐ sickle cell	☐ spina bifida	☐ other

Vaccinations: ☐ I have been fully vaccinated ☐ I get the flu shot regularly ☐ I have had some vaccines ☐ I haven't been vaccinated ☐ I have had travel vaccines (ie. Hepatitis) ☐ I don't know/don't remember

Adult Illnesses:

☐ ADD	☐ Alzheimer's	☐ arthritis	☐ asthma
☐ Cancer	☐ cerebral palsy	☐ chicken pox	☐ colitis
☐ CRPS(RSD)	☐ CVA(stroke)	☐ cystic kidney disease	☐ depression
☐ Diabetes	☐ eczema	☐ emphysema	☐ eye problems
☐ Fibromyalgia	☐ high blood pressure	☐ hepatitis	☐ HIV
☐ Heart disease	☐ influenza pneumonia	☐ liver disease	☐ lung disease
☐ Lupus	☐ multiple sclerosis	☐ Parkinson's	☐ pneumonia
☐ Psoriasis	☐ psychiatric condition	☐ scoliosis	☐ seizures
☐ Shingles	☐ STD's	☐ suicide attempts	☐ thyroid problems
☐ Vertigo	☐ Osteoporosis	☐ other:_________	

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: ___________ Description: ____

Year: ___________ Description: ____

Year: ___________ Description: ____

Year: ___________ Description: ____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: ____

____

Please list supplements you are currently taking:

1. ____ 5. ____
(Brand) (Supplement Name) (Daily Dose) (Brand) (Supplement Name) (Daily Dose)

2. ____ 6. ____
(Brand) (Supplement Name) (Daily Dose) (Brand) (Supplement Name) (Daily Dose)

3. ____ 7. ____
(Brand) (Supplement Name) (Daily Dose) (Brand) (Supplement Name) (Daily Dose)

4. ____ 8. ____
(Brand) (Supplement Name) (Daily Dose) (Brand) (Supplement Name) (Daily Dose)

Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

____ Alcohol
____ Artificial sweeteners
____ Candy or other sweets
____ Pop/soda
____ Chewing tobacco
____ Cigarettes
____ Cigars/pipes
8. ______ Coffee
9. ______ Fast food
10. _____ Fried foods
11. _____ Luncheon meats/hot dogs
12. _____ Margarine
13. _____ Milk/cheese/yogurt, etc.
14. _____ Non-herbal tea
15. _____ Refined flour/baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, tap
20. _____ Water, well
21. _____ Diet often (Y or N)

LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)
_____Sleep 7-9 hours/night (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin/Ibuprofen
_____ Asthma inhalers
_____ Beta blockers

_____ Birth control
_____ Chemotherapy
_____ Cortisone
_____ Diabetic medications
_____ Diuretics
_____ Heart medications
_____ High blood pressure
_____ Hormone Therapy

_____ Laxatives
_____ Insulin
_____ Recreational drugs
_____ Relaxants/Sleeping pills
_____ Thyroid medication
_____ Tylenol/acetaminophen
_____ Ulcer medications
OOther: ____________________

REVIEW OF SYSTEMS

Please put a check mark by all that apply:

Constitutional

__None __Chills __daytime drowsiness __fatigue
__Fever __loss of appetite __night sweats __weight gain/loss

Eyes/Vision

__None __blindness __blind spots __cataracts
__double vision __itchy eyes __photophobia __eye tearing

Ears/Nose/Throat

__None __dizziness __ear discharge __ear pain
__fainting __sore throats __headaches __hearing loss
__head injury __loss of smell __nosebleeds __nasal congestion
__runny nose __sinus infection

Respiration

__None __asthma __cough __cough up blood
__short of breath __produce sputum __wheezing

Cardiovascular

__None	__claudication	__heart problem	__heart murmur
__high bp	__low bp	__orthopnea	__palpitations
__ulcers	__varicose veins	__shortness of breath	__difficulty breathing lying down

Gastrointestinal

__None	__abdominal pain	__abnormal stool	__belching
__black/tarry stool	__constipation	__diarrhea	__difficulty swallowing
__heartburn	__hemorrhoids	__indigestion	__jaundice
__ulcers	__rectal bleeding	__loss of bowl control	

Female

__None/NA	__abnormal bleeding	__breast lump	__cramps
__breast pain	__burning urination	__frequent urination	__hormone therapy
__irregular menses	__vaginal discharge	__urine retention	__urine incontinence
__prolapse	__painful intercourse	__fecal in continence	

I am currently pregnant____ Number of weeks_____ I am not currently pregnant__

Age of first menses____ Age when menopause began____ Date of last menstrual period___________

Number of complicated pregnancies____ Number of uncomplicated pregnancies____ Number of C-sections___

Number of vaginal deliveries___ Number of miscarriages___ Number of terminated pregnancies___

Number of weeks/months postpartum (if within last 2 years)______________

Male

__None/NA	__erectile dysfunction	__burning urination	__hesitancy/dribbling
__frequent urination	__urine retention	__urine incontinence	__prostate problems

Skin

__None	__change in skin color	__change in nail texture	__hair loss
__hives	__skin disorders	__itching	__numbness
__rash	__skin lesions/ulcers	__varicosities	

Nervous System

__None	__dizziness	__facial weakness	__headache
__limb weakness	__loss of memory	__loss of consciousness	__numbness
__seizures	__sleep disturbance	__slurred speech	__stress
__stroke	__loss of balance	__unsteady gait	

Psychological

__None	__anxiety	__behavioral change	__bi-polar disorder
__confusion	__convulsions	__depression	__insomnia
__loss of appetite	__memory loss	__mood change	

Hematologic

__None	__anemia	__bleeding	__blood clotting
__blood transfusion	__bruise easily	__fatigue	__lymph node swelling

Do you crave certain foods? Y/N ____

Do you have energy crashes? Y/N Time/s: ____

Employer?Job?____

Hobbies? Sports? Activities?____

Signature____ Date_______________________________