Akita Chiropractic, **Timothy Akita, DC**

130 NW Miller Ave., Gresham, OR 97030 Phone: 503-665-2344 Fax: 503-665-2337

New Patient Intake Form

Patient Name _____ Date _____

Address _____ City _____ State ____ Zip Code _____

Phone: Home _____ Work _____ Cell_____

Birth Date _____ Age _____ Gender: M or F

Single _____ Married _____ Widowed _____

Occupation _____ Employer _____

Insurance Company _____

Insured's Name _____ Employer _____

Insured's ID Number _____ Insured's Birth Date _____

Reason for your visit today? _____

What caused your complaint? _____

First date of symptoms _____ Is your condition getting better _____ worse _____ same _____

Are your symptoms: constant _____ come and go ____ depends on activity _____

Did the pain appear immediately ____ slowly over time ____ quickly after injury ____

Is it painful to: sit ____ stand ____ bend ____ walk ____ reach ____ climb stairs ____ get dressed _____

Get in/out of car _____ lift ____ other _____

What have you used for this condition? Ice ____ heat ____ bed rest ____ wraps/braces ___ traction ___

Aspirin ____ Tylenol ____ Advil ____ other _____

How many times have you had this condition in the past? _____

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Patient Name _____ Date _____

Any broken bones and when? _____

Any motor vehicle collisions and when? _____

Any surgeries and when? _____

List any allergies/ drug allergies? _____

List any medications, vitamins, pain killers, birth control pills _____

Are you pregnant? _____ What month? _____ Age of children? _____

How often do you use: Tobacco? _____ Alcoholic beverages? _____

Caffeinated beverages? _____

Do you exercise? _____ How often? _____

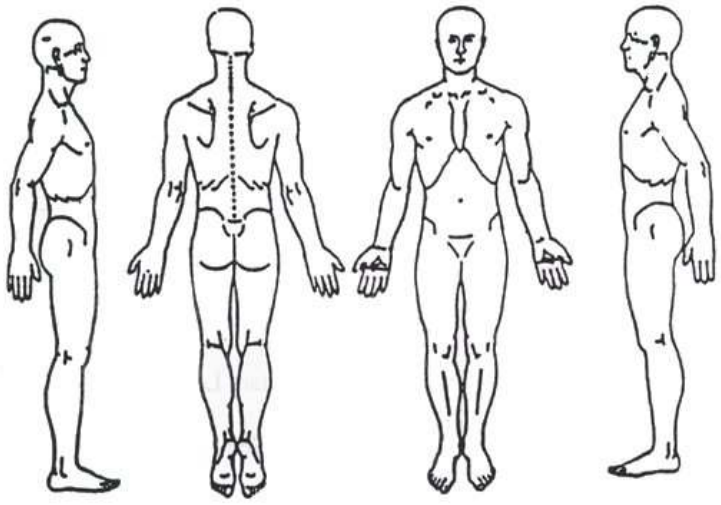
Do you sleep on your back ____ side ____ stomach? ____ How many hours of sleep per night? _____

Please put a mark on the scale below to show how bad your discomfort has been recently.

No Pain Severe Pain

0 ----------1 ----------2 ----------3 ---------4 ----------5 ----------6 ---------7 ----------8 ----------9 ----------10

Please circle your current areas of pain on the figures below:



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Patient Name _____ Date _____

Please check all that apply to you:

Recent infection
Recent fever
HIV/AIDS
Diabetes
Corticosteroid use
Arthritis
Stroke, Give Date _____
High blood pressure
High cholesterol/triglycerides
Dizziness/fainting
Urinary retention
Aortic aneurysm
Cancer/Tumor
Osteoporosis
Asthma
Hepatitis/Liver Disease
Rheumatic Fever
Irregular Moles
Persistent Cough
Multiple Sclerosis
Kidney Disease/ Stones
Pacemaker
Tuberculosis
Hands/feet: cold ____ hot ____
Stomach ulcer/bleeding ulcer

Prostate Problems
Frequent Urination
Abnormal Weight Gain/Loss
Epilepsy/Seizures
Visual Disturbances
Low Back Pain
Middle Back Pain
Neck Pain
Leg Pain or Numbness
Deafness/Hearing Aid
Pain At Night
Arm or Hand Numbness
Bleeding Disorder
Migraines/Many Headaches
Thyroid Disease
Sore That Won't Heal
Irregular Heartbeat/Murmur
Severe Menstrual Pain
Herpes/Shingles/Chicken Pox
Mononucleosis
Tinnitus
Rectal Bleeding
Shortness of Breath/Emphysema
Acid Reflux Disease

Do you have a family history of the following? Who? Alive or deceased? If deceased, what year?

Cancer _____
Diabetes _____
High Blood Pressure _____
Cardiovascular Disease _____

I certify that the above information is complete and accurate. I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. If the insurance information is not accurate or chiropractic services are not covered by my health insurance, then I understand that I am personally responsible for all services rendered. I agree to notify this doctor immediately whenever I have changes in my health condition or insurance coverage in the future. I also give authorization to Dr. Akita to contact my family physician if necessary.

Patient Signature _____ Date _____