BOOE CHIROPRACTIC & PRIMARY CARE
www.BooeClinic.com
615.864.4247
Dr. Matthew William Booe, D.C.

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NEW PATIENT INTAKE FORM

Title: *(Circle one)* Mr. Mrs. Ms. Miss Dr. Other _____

First _____ **M.I.** _____ **Last** _____ **Sex:** Male / Female

Address _____

City _____ **State** _____ **Zip Code** _____

Height _____ **Weight**_____ **Date of Birth** _____/_____/_____

Cell Phone (_____**)** _____-_____ **Email** _____

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

EMPLOYER DATA

Employer _____ **Occupation**_____

EMERGENCY CONTACT

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____**)** _____-_____ **Cell Phone (**_____**)** _____-_____

How did you hear about our office? _____

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MEDICAL CONDITIONS

(Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Allergies _____

SURGERIES

(Please list all surgical procedures you have had)

_____

_____

SOCIAL HISTORY

(Circle all that apply to you)

Caffeine use……	occasional	often	never
Drink Alcohol…….	occasional	often	never
Exercise……..	occasional	often	never
Drink Water……	<64 oz/day	>64 oz/day	never
Cigarettes……	<1 pack/day	>1 pack/day	never
Sleep……	<8 hours/night	>=8 hours/night	Insomnia

Are you pregnant? *(Please Circle)* **Yes** **No**

Last Physical Exam?

MEN:
General Physical:_____
Prostate:_____

WOMEN:
General Physical:_____
OBGYN visit:_____

FAMILY HISTORY

(Circle all that apply and list relative type)

Arthritis:_____ **Thyroid:**_____
Cancer:_____ **Stroke:**_____
Diabetes:_____ **Hypertension:**_____
Heart Disease:_____ **Other:**_____

MEDICATIONS

(Please list all medications you are currently taking)

_____ _____
_____ _____
_____ _____
_____ _____

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REVIEW OF SYSTEMS

(Please circle if you have had trouble with any of the following)

RESPIRATORY
- Asthma
- Tuberculosis
- Shortness of Breath
- Emphysema
- Cold/Flu
- Cough
- Wheezing

EYES
- Glaucoma
- Double Vision
- Blurred Vision
- Glasses or Contacts

CARDIOVASCULAR
- Poor Circulation
- Hypertension
- Aortic Aneurism
- Heart Disease
- Heart Attack
- Chest Pain
- High Cholesterol
- Pace Maker
- Jaw Pain
- Irregular Heartbeat
- Swelling of Legs

GENITOURINARY
- Kidney Disease
- Burning Urination
- Frequent Urination
- Blood in Urine
- Kidney Stones
- Lower Flank Pain

PSYCHIATRIC
- Depression
- Anxiety
- Stress

GASTROINTESTINAL
- Gall Bladder Problems
- Bowel Problems
- Constipation
- Liver Problems
- Ulcers
- Diarrhea
- Nausea/Vomiting
- Bloody Stools
- Poor Appetite

ENDOCRINE
- Thyroid
- Diabetes
- Hair Loss
- Menopausal
- PMS

EARS, NOSE, & THROAT
- Difficulty Swallowing
- Dizziness
- Hearing Loss
- Sore Throat
- Nosebleeds
- Bleeding Gums
- Sinus Infections

IMMUNOLOGIC
- Hives
- Immune Disorder
- HIV/AIDS
- Cortisone Use

MUSCULOSKELETAL
- Gout
- Arthritis
- Joint Stiffness
- Muscle Weakness
- Osteoporosis
- Broken Bones
- Joints Replaced
- Neck Pain
- Low Back Pain
- Upper Back Pain

NEUROLOGIC
- Strokes
- Seizures
- Head Injury
- Brain Aneurysm
- Numbness
- Severe Headaches
- Pinched Nerves
- Parkinson's
- Carpal Tunnel
- Vertigo

CONSTITUTIONAL
- Weight Loss/Gain
- Low Energy Level
- Difficulty Sleeping

HEMATOLOGIC
- Hepatitis
- Blood Clots
- Cancer
- Bruising
- Bleeding
- Fever, Chills
- Sweating
- Varicose Vein

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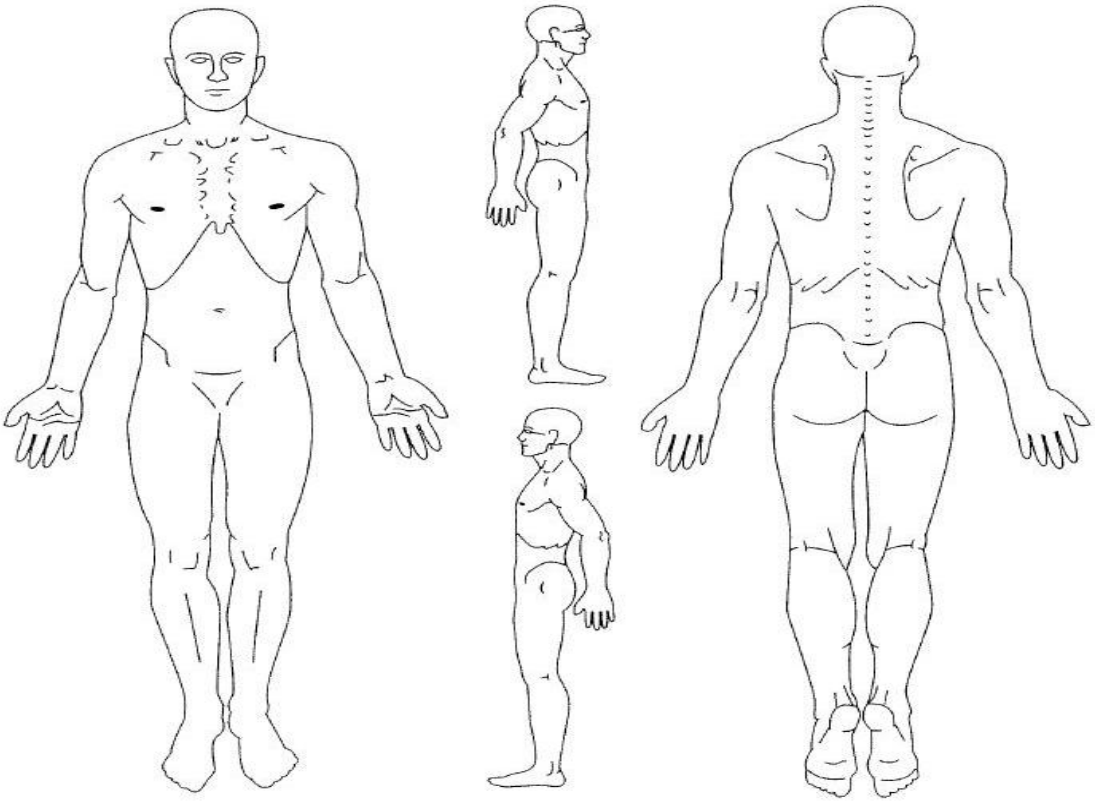
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=NUMBNESS B=BURNING S=SHARP T=TINGLING A=DULL ACHE



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Does anything improve your pain? Yes No **If Yes, please list:**_____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? _____

How often do you experience your symptoms? *(Please circle)*

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)