



Lor Chiropractic Clinic
4701 N. 76th St. Suite 201
Milwaukee, WI 53218
(414) 464-1080

Patient Intake Form

Date _____	Phone 1 _____	Job Status
First Name _____	<input type="radio"/> Home <input type="radio"/> Mobile <input type="radio"/> Work <input type="radio"/> Other	<input type="radio"/> Not Employed <input type="radio"/> Employed
Last Name _____	Phone 2 _____	<input type="radio"/> Part-Time Student <input type="radio"/> Retired
DOB _____	<input type="radio"/> Home <input type="radio"/> Mobile <input type="radio"/> Work <input type="radio"/> Other	<input type="radio"/> Full-Time Student
Sex <input type="radio"/> Male <input type="radio"/> Female	Fax _____	Marital Status
SSN _____	Email _____	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other
Address _____	Employer _____	Receive Appointment Reminders
City _____	Employer Phone _____	<input type="radio"/> Declined <input type="radio"/> Voice <input type="radio"/> Text <input type="radio"/> Email
State _____	Occupation _____	Height _____ Weight _____
Zip Code _____		_____ ' _____ " _____ lbs

Reason For Visit: ☐ New Patient ☐ Adjustment ☐ Physical ☐ Consultation ☐ X-Rays ☐ Therapy ☐ Injury
☐ Report of Findings ☐ Auto Accident ☐ Re-Examination ☐ Other _____

Referred By: ☐ Provider ☐ Friend ☐ Family ☐ Other _____
Referred By Name _____

How Heard of Us: ☐ Walk in ☐ Referral ☐ Phone Book ☐ Website
☐ Advertisement ☐ Other _____

Demographics

Preferred Language: _____ **Dominance:** ☐ Right ☐ Left ☐ Ambidextrous

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Other Specific Islander ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Non- Hispanic or Latino ☐ Unknown ☐ Other _____

Insurance Information

Primary Insurance:

Insured First Name _____
Insured Last Name _____
DOB _____
Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Visit Copay _____
Co-Ins % _____
Deductible _____ Applied _____
\$/Year _____ Visits/Year _____ Therapy Visits/Year _____
PCP Referral Required ☐ Yes ☐ No
Policy Effective Date _____
Cal Yr / Other _____
Other _____

Secondary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

\$/Year _____ Visits/Year _____ Therapy Visits/Year _____

PCP Referral Required ☐ Yes ☐ No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Emergency Contact Information

First Name _____

Relationship _____

Last Name _____

Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Other _____ | | | | |

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries:

Traumas:

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Does the pain travel anywhere else? _____**Do you know what caused the problem?** _____**Do you notice the pain during a certain time of day?** _____**Frequency:** _____ times per ☐ Day ☐ Week ☐ Month ☐ Year**Duration:** Lasting _____ ☐ Minutes ☐ Hours**Onset:** Have had symptoms over the past _____ ☐ Days ☐ Weeks ☐ Months ☐ Years**Intensity:** ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe**Is your condition:** ☐ Same ☐ Better ☐ Worse**Rate your pain:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10*0 being no pain at all and 10 being the worst pain imaginable***Quality: Describe your pain:** ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing**Aggravating Factors: What makes the problem worse?** ☐ nothing ☐ most movements ☐ bending ☐ carrying things☐ coughing ☐ driving ☐ eating ☐ exercise ☐ going down stairs ☐ going from lying to sitting☐ going from lying to standing ☐ going from sitting to standing ☐ heat ☐ housework ☐ ice ☐ jogging ☐ lifting☐ lying down ☐ massage ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching ☐ taking a deep breath ☐ turning☐ twisting ☐ walking ☐ working**Relieving Factors: What makes the problem better?** ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching☐ walking ☐ wraps**What daily activities are affected due to the problem?** ☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ going from laying down to sitting☐ going from sitting to standing ☐ grooming ☐ house work ☐ laying down ☐ lifting ☐ oral care ☐ sex☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting☐ transferring ☐ using technology ☐ using phone ☐ walking ☐ watching tv ☐ working ☐ yard work**Have you been given a diagnosis for this problem? If so, what was the diagnosis?** _____**What treatment(s) have you tried for your condition?** ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy☐ Chiropractic ☐ Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: ☐ Good ☐ Insufficient ☐ Erratic

☐ Low (Time of Day) _____ ☐ High (Time of Day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ☐ None ☐ Low ☐ Moderate ☐ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ☐ Yes ☐ No If yes, how much? _____

Daily Habits

Do you smoke? ☐ Never smoked ☐ Unknown if ever smoked ☐ Unknown if currently smokes

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: ☐ Unknown ☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ 11 to 15 ☐ 16 to 20 ☐ 21 to 25 ☐ Over 25

Weekly Alcoholic Drinks: ☐ Unknown ☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ 11 to 15 ☐ 16 to 20 ☐ 21 to 25 ☐ Over 25

Do you exercise regularly? ☐ no ☐ light ☐ moderate ☐ heavy

Review of Systems

Musculoskeletal: Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm ☐ Persistent Coughing

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps

☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing

☐ Other _____

Eyes: Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma

☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

Ears: Please check all that apply ☐ None

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing

☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply ☐ None

- ☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds
☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

Throat/Mouth: Please check all that apply ☐ None

- ☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness
☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling
☐ Thrush ☐ Tooth pain ☐ Other _____

Urinary: Please check all that apply ☐ None

- ☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary track infections
☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)
☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

Gastrointestinal: Please check all that apply ☐ None

- ☐ Change in appetite ☐ Change in bowl habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea
☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Endocrine: Please check all that apply ☐ None

- ☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst
☐ Frequent urination ☐ Heat intolerance ☐ Sweating

Vascular/Hematologic: Please check all that apply ☐ None

- ☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply ☐ None

- ☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia
☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness
☐ Worry/anxiety ☐ Other _____

Psychiatric: Please check all that apply ☐ None

- ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

Female:

Are you pregnant? ☐ Yes ☐ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply ☐ None

- ☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections
☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps
☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge
☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

Male: Please check all that apply ☐ None

- ☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination
☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____
and assign directly to Lor Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

Lor Chiropractic Clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

Signature of Patient, Parent, Guardian or Personal Representative Date _____

Print Name of Patient, Parent, Guardian or Personal Representative Date _____