Bowen Chiropractic
Joanne L. Bowen, D.C.

Willow Health and Wellness Center
3090 Belgium Road, Baldwinsville, NY
Phone: 315-729-0573
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Patient Intake Form

Date ______

First Name ______
Last Name ______
DOB ______
Sex ◯ Male ◯ Female
SSN XXXXXXXXXXXXXXXXXXXXXX
Address ______
City ______
State ______
Zip Code ______

Phone 1 ______
◯ Home ◯ Mobile ◯ Work ◯ Other
Phone 2 ______
◯ Home ◯ Mobile ◯ Work ◯ Other
Fax ______
Email ______
Employer ______
Employer Phone ______
Occupation ______

Job Status
◯ Not Employed ◯ Employed
◯ Part-Time Student ◯ Retired
◯ Full-Time Student

Marital Status
◯ Single ◯ Married ◯ Other

Receive Appointment Reminders
◯ Declined ◯ Voice ◯ Text ◯ Email

Height ___ ' ___ "
Weight ___ 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

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 ______

Dominance: ◯ Right ◯ Left ◯ Ambidextrous

Insurance Information

Primary Insurance:

Insured First Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Insured Last Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
DOB XXXXXXXXXXXXX
Insurance Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Insurance Phone XXXXXXXXXXXXXXXXXXXX
ID # XXXXXXXXXXXXXXXX Group # XXXXXXXXXXXXX
Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay XXXXXXXXXXXXXXXXXX
Co-Ins % XXXXXXXXXXX
Deductible XXXXXXXXX Applied XXXXXXXX
$/Year XXX Visits/Year XXX Therapy Visits/Year XXX
PCP Referral Required ◯ Yes ◯ No
Policy Effective Date XXXXXXXXXXXXX
Cal Yr / Other XXXXXXXXXXXX
Other XXXXXXXXXXXXXXXXXXXXXX

Secondary Insurance:

Insured First Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Insured Last Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DOB XXXXXXXXXXXXX

Insurance Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Insurance Phone XXXXXXXXXXXXXXXXXXX

ID # XXXXXXXXXXXXXXX Group # XXXXXXXXXXXX

Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay XXXXXXXXXXXXXXXX

Co-Ins % XXXXXXXXXX

Deductible XXXXXXXX Applied XXXXXXXX

$/Year XXX Visits/Year XXX Therapy Visits/Year XXX

PCP Referral Required ◯ Yes ◯ No

Policy Effective Date XXXXXXXXXXXXX

Cal Yr / OtherXXXXXXXXXXXXX

Other XXXXXXXXXXXXXXXXXXXXXXXX

Emergency Contact Information

First Name ____________________ Relationship ____________________

Last Name ____________________ Phone 1 __________ Phone 2 __________

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

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

☐ 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

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

☐ 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 tract 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 bowel 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 intolerence ☐ 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 ____

End of Form Acknowledgement

Chiropractic Care

☐ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

Privacy Verification

☐ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

X-ray Verification

☐ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

Date of last menstrual period.

Permission to Contact

☐ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification

☐ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

General Verification

☐ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

______________________________ Date ____________

Signature of Patient, Parent, Guardian or Personal Representative

______________________________ Date ____________

Print Name of Patient, Parent, Guardian or Personal Representative