GCW Patient Intake Form

Please answer **all** questions and sign **every** page.

Name _____ My Pronouns Are _____Date _____
Last Name First Name Middle

Address _____ City_____ State _____ Zip _____

Age _____ Birth date _____ ☐ Female ☐ Male ☐ Non-Binary ☐ Decline to answer ☐ Other_____

Status ☐ Married ☐ Single ☐ Partnered ☐ Other ☐ Minor (under 18) No. of Children _____

PHONE NUMBERS / CONTACT (check preferred contact)

Home ☐ _____ Business ☐ _____ Cell ☐ _____

E-mail address _____ ☐ Check if you *do not* want us to contact you via e-mail

Person Responsible for this account _____

**** INSURANCE ** PLEASE COMPLETE ****

Please indicate your Primary Insurance _____

Primary Subscriber's Name _____ Subscriber's Birth Date ____/____/_____

MEMBER ID / POLICY # _____Group # _____ Co-Payment $ _____

EMPLOYMENT INFORMATION / EMERGENCY CONTACT

Occupation _____ ☐ Full Time ☐ Part Time ☐ F/T Student ☐ Retired

In case of Emergency, Contact Name _____ Phone _____Relationship _____

What is the reason for your visit? _____

_____

How did your symptoms begin? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

How often do you experience your symptoms?

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

Please describe the nature of your symptoms? ☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling ☐ Other _____

Current Problem is the result of a: *Check all the apply* ☐ Work accident ☐ Car Accident ☐ Other, specify _____

PLEASE SIGN

Patient Signature _____ Date _____

Michelle L. Widmeier, DC - Operating as: Widmeier Chiropractic and Ground Control Wellness
Connecticut P: 203-505-2600 New York P: 718-541-9582 www.WidmeierChiropratic.com www.GroundControlWellness.com

Does the pain spread to other areas? ☐ No ☐ Yes (if so, where?) _____

How much has your pain interfered with your normal work (including outside the home and housework) ?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Other, specify _____

What activities aggravate your condition? _____

What makes it feel better? _____

Any Other Complaints? _____

_____

_____

OTHER DOCTORS SEEN FOR THIS CONDITION ☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ No one ☐ Other _____

Doctor's Name _____ Diagnosis _____

Other Doctor(s) Name _____

Did you have ☐ X-rays ☐ MRI ☐ CT ☐ Urinalysis ☐ Blood tests ☐ Other, specify _____

☐ Physical Therapy, duration? _____ ☐ Medication, list _____

What were the results of your care? _____

EXERCISE

☐ None ☐ Light ☐ Moderate ☐ Heavy ☐ Consists of _____

_____

HABITS

☐ Smoking (packs/day) _____ ☐ Do not smoke ☐ Quit smoking _____ yrs ago ☐ Alcohol (drinks/week) _____ ☐ Caffeine (drinks/week) _____

PLEASE LIST ALL PRESCRIBED MEDICATIONS , OVER-THE-COUNTER MEDICATIONS, HERBS, VITAMINS AND INHALERS:

NAME OF MEDICATION / WHY PRESCRIBED DOSAGE FREQUENCY USED

_____

_____

_____

_____

_____

PLEASE SIGN

Patient Signature _____ Date _____

Michelle L. Widmeier, DC - Operating as: Widmeier Chiropractic and Ground Control Wellness
Connecticut P: 203-505-2600 New York P: 718-541-9582 www.WidmeierChiropratic.com www.GroundControlWellness.com

REVIEW OF SYSTEMS: Please help us identify your potential health risks, check any that apply.

- ☐ Headache
- ☐ Migraines
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow / Upper Arm Pain
- ☐ Wrist / Hand Pain
- ☐ Hip / Upper Leg Pain
- ☐ Knee / Lower Leg Pain
- ☐ Ankle / Foot Pain
- ☐ Jaw Pain
- ☐ Joint Swelling / Stiffness
- ☐ Spinal Disc Pathology
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Blood Disorder
- ☐ Muscle Aches
- ☐ High / Low Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Condition (Heart Attack, Valve Disease / Blockage)
- ☐ Chest Pain (Angina)
- ☐ Shortness of Breath
- ☐ Vascular Condition / Stroke
- ☐ Lung Condition / Emphysema / COPD
- ☐ Asthma
- ☐ Abdominal Pain
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Liver / Gallbladder Disorder
- ☐ Heartburn / Indigestion / GERD
- ☐ Constipation
- ☐ Diarrhea
- ☐ Loss of Bowel Control
- ☐ Colitis
- ☐ Irritable Bowel
- ☐ Cancer / Tumor
- ☐ Thyroid Condition
- ☐ Bone Fractures
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney / Bladder Stones
- ☐ Kidney / Bladder Infection
- ☐ Loss of Bladder Control
- ☐ Dizziness
- ☐ Loss of Consciousness
- ☐ Visual Disturbances
- ☐ Earache
- ☐ Ringing in Ears
- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Skin Condition
- ☐ Loss of Appetite
- ☐ Abnormal Weight Gain
- ☐ Depression
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Allergies to: _____

PLEASE LIST ANY PRIOR MAJOR ILLNESSES OR CONDITIONS

_____

_____

_____

PLEASE LIST PRIOR INJURIES / SURGERIES / HOPITALIZATIONS:

REASON	YEAR	HOSPITAL	OUTCOME

PLEASE INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING CONDITIONS. WHICH FAMILY MEMBER?

☐ Rheumatoid Arthritis_____ ☐ Diabetes _____ ☐ Stroke_____

☐ Heart Condition (Heart Attack, Valve Disease / Blockage) _____ ☐ Cancer _____

☐ High Cholesterol _____ ☐ Other Serious health condition not listed _____

Is there anything else you would like the doctor to know about you, your condition, or your general health status? (Please describe) _____

_____

_____

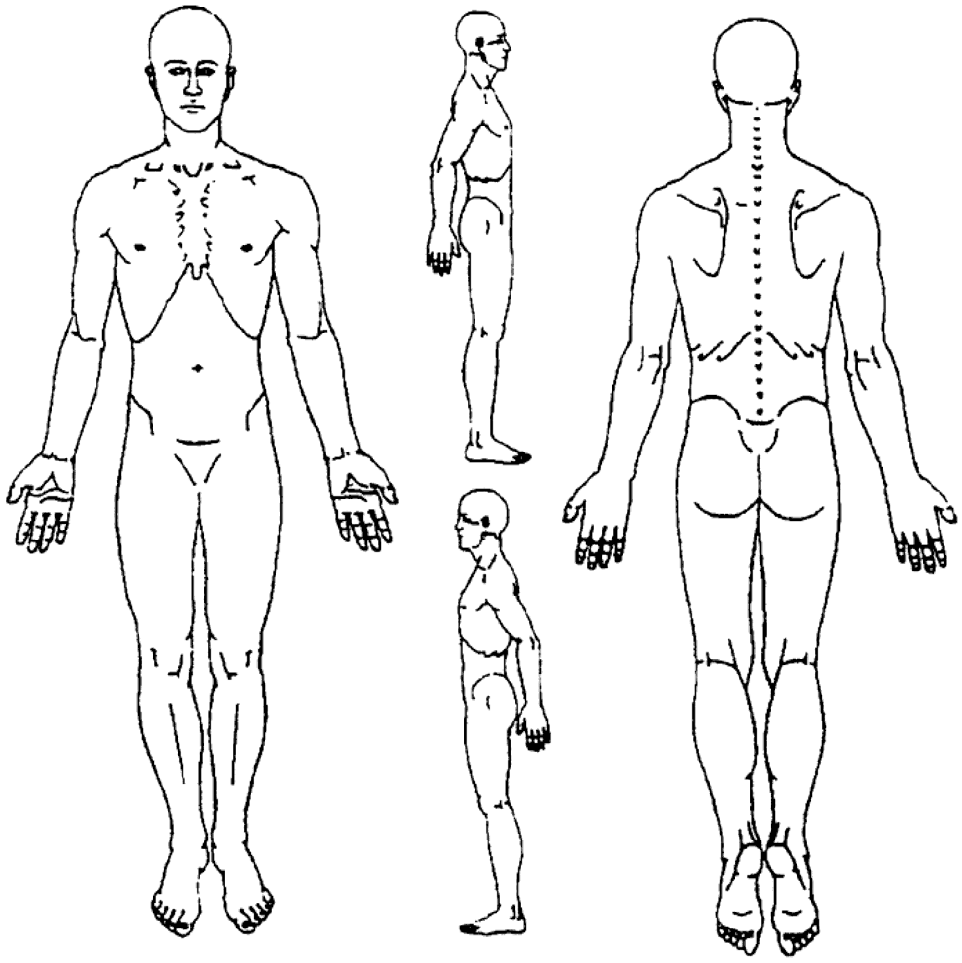
Michelle L. Widmeier, DC - Operating as: Widmeier Chiropractic and Ground Control Wellness
Connecticut P: 203-505-2600 New York P: 718-541-9582 www.WidmeierChiropratic.com www.GroundControlWellness.com

Who referred you to this office? _____ *May we thank them?* [ ]*yes* [ ]*no*

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Mark areas of radiation. Include all affected areas.

Use appropriate symbols:

Numbness - - - - Pins & Needles oooo Burning xxxx
Aching ** Stabbing ////**



VISUAL ANALOG PAIN SEVERITY SCALE

Please place a mark on the line that corresponds to your *current* pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN EVER

Please place a mark on the line that corresponds to your *average* pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN EVER

PLEASE SIGN

Patient Signature _____ Date _____

Michelle L. Widmeier, DC - Operating as: Widmeier Chiropractic and Ground Control Wellness
Connecticut P: 203-505-2600 New York P: 718-541-9582 www.WidmeierChiropratic.com www.GroundControlWellness.com