

New Patient Intake Form
Perfect Touch Massage & Chiropractic Ltd.
Dr. Nicole Klersy-Mohr D.C.

Name _____ Phone () _____ DOB _____

Address _____ City _____

State _____ Zip _____ E-mail: _____

In case of emergency: _____ Phone () _____

Preferred method of contact: _____

Reason for your visit to Perfect Touch Massage & Chiropractic Ltd. today: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Fertility Support | <input type="checkbox"/> Nutritional Support |
| <input type="checkbox"/> Endometriosis/PCOS Care | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Manual Chiropractic Adjustments |
| <input type="checkbox"/> Lab work/other diagnostics | <input type="checkbox"/> Other (explain): _____ |

How did you hear about our office? _____

Were you referred by another health care provider? Yes / No If Yes, who? _____

I understand and agree that the doctors at Perfect Touch Massage & Chiropractic Ltd. have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____ **Date**

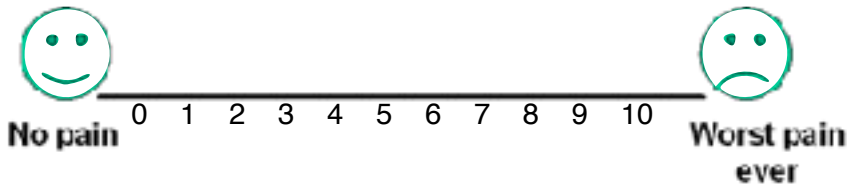
_____ **Signature**

Physician's Signature: _____ **Date:** _____

DOCTORS NOTES: _____

If you have a musculoskeletal complaint today:
 (if you are here about woman's health only, skip to female history on pg. 2)

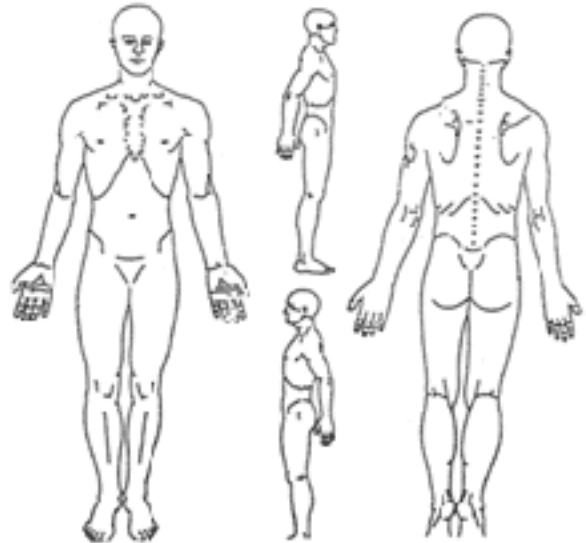
What is your musculoskeletal complaint? _____
 Is there pain associated with your complaint today? Yes / No If Yes, mark where that pain is on a scale from 0-10?



Please mark line on the left with an X
 0 = No pain 10 = Worst pain ever

On the diagram to the right, please mark the following symptoms, if you are experiencing them:

“/” for stabbing pain,
 “B” for burning pain,
 “D” for dull pain,
 “A” for aching
 “N” in areas of numbness
 “T” in areas of tingling
 “St” in areas of stiffness
 “Sw” in areas of swelling
 “C” in areas of cramping



Have you seen anyone else for the **musculoskeletal** condition? Yes / No If Yes, who? _____
 Have you missed work for this condition? Yes / No If Yes, how much? _____
 Have you tried any self-treatments for this condition? _____
 If Yes, what makes it feel better? _____ feel worse? _____
 Have you ever been treated for a similar problem? (If so please describe): _____

Do you have any other complaints or concerns? _____
 What do you think is causing your current musculoskeletal complaint? _____

Past History

How do you feel that your health is overall? _____
 Please list any/all past injuries, illnesses, surgeries & hospitalizations with dates of occurrence: _____

Have you had diagnostic tests? **(please check all that apply)**

- | | |
|---|---|
| <input type="checkbox"/> Blood labs (CBC, cholesterol, blood sugar, etc.) | <input type="checkbox"/> Stool sample |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Hormone panel (blood/saliva) |
| <input type="checkbox"/> Pap smear (woman) | <input type="checkbox"/> Ultrasound (reproductive organs) |
| <input type="checkbox"/> Tuberculin test | <input type="checkbox"/> Other: _____ |

Where did you get these tests performed? _____

**If we need copies of your past tests we will discuss this with you at your next visit.*

Childhood Illness's (please check all that apply)

- | | | | |
|---|------------|---|------------|
| <input type="checkbox"/> Measles | Age: _____ | <input type="checkbox"/> Polio | Age: _____ |
| <input type="checkbox"/> Chicken pox | Age: _____ | <input type="checkbox"/> Scarlet fever | Age: _____ |
| <input type="checkbox"/> Rubella | Age: _____ | <input type="checkbox"/> Rheumatic fever | Age: _____ |
| <input type="checkbox"/> Whooping cough | Age: _____ | <input type="checkbox"/> Other: (please list) _____ | |

Current Health History

Are you currently taking prescription or over the counter medications? (Please list them below including dosage)

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Are you currently taking any herbs or nutritional supplements? (Please list them below)

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Do you have any known allergies? (Please list them)

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
|----------|----------|----------|

Is your condition getting: (circle) Better | Worse | Staying the same

How have you handled your medical conditions in the past? (circle all that apply)

- Medications | Nutrition/Diet | ER visit | Routine doctor visits | Chiropractic | Vitamins | Holistic care
 Exercise | Other: _____

How was the outcome of above: (circle one)

- Great | Okay | Bad | No change | Not sure | Only worked for a short time | Still trying | Did not get worse

What things in your life have been affected by this condition? (family/job/finances/marriage/future ability/sleep/time/freedom) _____

Have others been affected by your health condition? if so how... _____

Are you concerned this health condition will develop into other issues? _____

What has this problem cost you? (time/money/relationships/happiness/freedom/sleep/promotions/etc) _____

Social & Environmental History

- Single Married Divorced Widowed

Do you feel safe at home? Yes / No If you don't feel safe, do you have somewhere safe to go? Yes / No

Do you have a support system? Yes / No

Do you feel rested upon waking in the morning? Yes / No How many hours do you sleep each night? _____

Do you get tired during the day and want to rest? Yes / No If yes, explain: _____

What is a typical day look like for food consumption?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

What is your occupation? _____

Are you currently working with any materials you see that could be harmful? Yes / No If yes, list: _____

Have you worked with any materials that were harmful in the past? Yes / No If yes, list: _____

Have you built a house and/or lived in a brand new house in the past 3 years? Yes / No

Do you wear your seatbelt in the car? Yes / No

Are you involved in sports, hobbies or special interests? Yes / No If yes, please list: _____

Family History

Please check box and circle all that apply. (Put the age they are currently if alive and age at time of death):

- | | | | | | |
|---|------------------|------------|---|------------------|------------|
| <input type="checkbox"/> Mother | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Maternal Grandmother | A / Dec. | AGE: _____ |
| <input type="checkbox"/> Father | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Maternal Grandfather | A / Dec. | AGE: _____ |
| <input type="checkbox"/> Brother/Sister | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Paternal Grandmother | A / Dec. | AGE: _____ |
| <input type="checkbox"/> Brother/Sister | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Paternal Grandfather | A / Dec. | AGE: _____ |
| <input type="checkbox"/> Brother/Sister | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Child | Alive / Deceased | AGE: _____ |
| <input type="checkbox"/> Brother/Sister | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Child | Alive / Deceased | AGE: _____ |
| <input type="checkbox"/> Brother/Sister | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Child | Alive / Deceased | AGE: _____ |
| <input type="checkbox"/> Brother/Sister | Alive / Deceased | AGE: _____ | <input type="checkbox"/> Spouse | Alive / Deceased | AGE: _____ |

Does anyone in your family have: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Drug addiction |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes Type 2 (insulin dependent) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Dementia/Alzheimer's Disease | <input type="checkbox"/> Asthma | (Type: _____) |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anyone with similar symptoms |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental illness | as you today? |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcoholism | |

Where do you see your self 1 to 3 years if you do not address this health issue? _____

What would be better in your life if you had this health issue controlled? _____

What do you desire most from working with us? _____

Is there any other information you feel will be important for Dr. Nicole to know? (coping style, faith, etc.) _____

Review of Systems

General

- Past / Present Weight loss/gain
- Past / Present Fatigue
- Past / Present Fever or chills
- Past / Present Weakness
- Past / Present Trouble sleeping

Skin

- Past / Present Rashes
- Past / Present Lumps
- Past / Present Itching
- Past / Present Dryness

Head

- Past / Present Headache
- Past / Present Head injury
- Past / Present Neck pain

Ears

- Past / Present Decreased hearing
- Past / Present Ringing in ears
- Past / Present Earache
- Past / Present Drainage

Eyes

- Past / Present Vision Loss/Changes
- Past / Present Glasses or contacts
- Past / Present Pain
- Past / Present Redness
- Past / Present Blurry or double vision
- Past / Present Flashing lights
- Past / Present Specks
- Past / Present Glaucoma
- Past / Present Cataracts
- Past / Present Last eye exam:

Nose

- Past / Present Stuffiness
- Past / Present Discharge
- Past / Present Itching
- Past / Present Hay fever
- Past / Present Nosebleeds
- Past / Present Sinus pain

Throat

- Past / Present Bleeding
- Past / Present Dentures
- Past / Present Sore tongue
- Past / Present Dry mouth
- Past / Present Sore throat

Please check if currently using:

- Tobacco If yes, How many cigarettes/day? _____ Age when started? _____
- Alcohol If yes, How often? _____ How many drinks per occasion? _____
- Recreational drugs

- Past / Present Thrush
 - Past / Present Non-healing sores
- ### Neck
- Past / Present Lumps
 - Past / Present Swollen glands
 - Past / Present Pain
 - Past / Present Stiffness

Breasts

- Past / Present Lumps
- Past / Present Pain
- Past / Present Discharge
- Past / Present Self-exams
- Past / Present Breast feeding (woman)

Respiratory

- Past / Present Cough
- Past / Present Sputum
- Past / Present Coughing up blood
- Past / Present Shortness of breath
- Past / Present Wheezing
- Past / Present Painful breathing

Cardiovascular

- Past / Present Chest pain or discomfort
- Past / Present Tightness
- Past / Present Palpitations
- Past / Present Shortness of breath (SOB) w/activity
- Past / Present Difficulty breathing lying down
- Past / Present Swelling
- Past / Present Sudden awakening from sleep w/SOB

Gastrointestinal

- Past / Present Swallowing difficulties
- Past / Present Heartburn
- Past / Present Change in appetite
- Past / Present Nausea
- Past / Present Change in bowel habits
- Past / Present Rectal bleeding
- Past / Present Constipation
- Past / Present Diarrhea
- Past / Present Yellow eyes or skin

Urinary

- Past / Present Frequency
- Past / Present Urgency
- Past / Present Burning or pain
- Past / Present Blood in urine
- Past / Present Incontinence
- Past / Present Change in urinary strength

Vascular

- Past / Present Calf pain with walking
- Past / Present Leg cramping

Musculoskeletal

- Past / Present Muscle or joint pain
- Past / Present Stiffness
- Past / Present Back pain
- Past / Present Redness of joints
- Past / Present Swelling of joints
- Past / Present Trauma

Neurologic

- Past / Present Dizziness
- Past / Present Fainting
- Past / Present Seizures
- Past / Present Weakness
- Past / Present Numbness
- Past / Present Tingling
- Past / Present Tremor

Hematologic

- Past / Present Ease of bruising
- Past / Present Ease of bleeding

Endocrine

- Past / Present Heat or cold intolerance
- Past / Present Sweating
- Past / Present Frequent urination
- Past / Present Thirst
- Past / Present Change in appetite

Psychiatric

- Past / Present Nervousness
- Past / Present Stress
- Past / Present Depression
- Past / Present Memory loss