Aligned Chiropractic Dr. Jack Marchalewicz

New Patient Intake Form

General Information

First Name: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Sex: □ Male □ Female □ Other identity: _____

Marital Status: □ Single □ Married □ Divorces □ Widowed/Widower □ Other: _____

Employer Information

Employment Status: □ Employed □ Unemployed □ Student □ Other: _____

Your Occupation: _____

Employer: _____

Work Phone: _____

Spouse Information

First Name: _____ Middle: _____ Last: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Emergency Contact Information

□ Same as spouse information

First Name: _____ Middle: _____ Last: _____

Home Phone: _____ Cell Phone: _____

Relationship to Patient: _____

Insurance Information

Do you have health insurance? □ No □ Yes

Name of party responsible for payment: □ I am responsible □ Same as spouse information

First Name: _____ Middle: _____ Last: _____

Home Phone: _____ Cell Phone: _____

Health Insurance Company Name: _____ Member ID: _____

Auto/Worker Comp Insurance: _____ Claim #: _____

Contact Person: _____ Phone: _____

Signatures

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature: _____ Date: _____

Spouse's or guardian's signature: _____ Date: _____

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Patient Name:_____ Date:_____

Review of Systems

Have you had any of the following respiratory (breathing) issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular Disease □ Heart attacks/MIs □ Hypertension
□ Pacemaker □ Irregular heartbeat □ Heart disease/ problem
□ Other _____ □ None of the above

Have you had any of the following neurological (nerve-related) issues?

□ Visual changes/loss of vision □ History of seizures □ Headaches □ Memory loss □ Loss of sense of smell
□ One-side weakness of face or body □ Tremors □ Stroke/TIAs □ One-sided decreased feeling in the face or body
□ Other _____ □ None of the above

Have you had any of the following endocrine (glandular/hormonal) issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in urine) □ Incontinence (can't control) □ Dialysis
□ Difficulty urinating □ Kidney disease □ Bladder infections
□ Other _____ □ None of the above

Have you had any of the following gastroenterological (stomach-related) issues or procedures?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Hepatitis or liver disease □ Vomiting blood □ Bowel incontinence
□ Bloody or black tarry stools □ Gastroesophageal reflux/heartburn
□ Other _____ □ None of the above

Have you had any of the following hematological (blood-related) issues or procedures?

□ Anemia □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Enlarged lymph nodes □ Anticoagulant therapy
□ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following oncological (cancer-related) issues?

□ Abnormal bleeding/bruising □ Fevers/chills/sweats/unexplained weight loss □ Current/past oncology disease:
□ Other _____ □ None of above

Have you had any of the following dermatological (skin-related) issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorder □ Other _____ □ None of the above

Have you had any of the following musculoskeletal (bone/muscle– related) issues?

□ Rheumatoid arthritis □ Broken bones □ Osteoarthritis □ Gout □ Spinal fracture
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Spinal surgery □ Joint surgery
□ Other _____ □ None of the above

Have you had any of the following psychological issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

_____

Medications: (You may provide own medication list)

Medication	Reason for taking

Aligned Chiropractic

Dr. Jack Marchalewicz, DC, PTA, CEAS

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

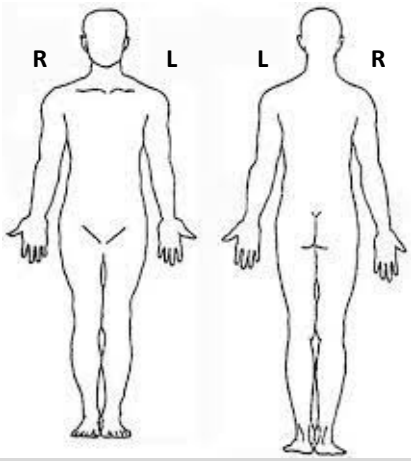
- **Did the symptom begin □ suddenly or □ gradually?**
  - When did the symptom begin? _____
  - How did the symptom begin? _____

In diagram below, use the following letters to indicate **Type** and **Location** of your symptoms.

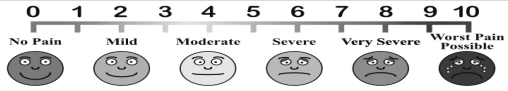
A= Ache **O**= Other

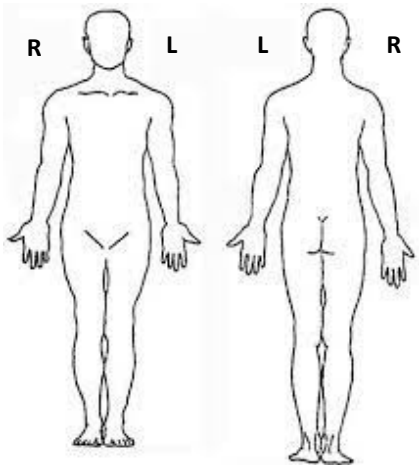
B= Burning **P**= Pins & Needles

N= Numbness **S**= Stabbing/Sharp



In diagram below, use the following number pain scale to indicate your symptom **Intensity** and **Location** .





N= Neck and Upper Back **M**= Mid-Back **L**= Lower Back

What makes the symptoms worse?	N	M	L
arm movement			
arm position			
bending backwards			
bending at the waist			
clinching / grinding teeth			
computer work			
coughing			
driving			
exercise			
getting in or out of bed			
holding baby			
house work			
lifting object			
lifting leg (right/left/both)			
lying on back			
lying on side (right or left)			
poor posture			
reaching			
reading			
resting			
rolling in bed			
sit to stand			
sitting			
sleeping			
stair climbing			
standing			
stress			
stretching			
twisting			
using smartphone or tablet			
walking			
yardwork			
nothing			
Other:			

What makes the symptoms better?	N	M	L
acupuncture			
arm position			
assistive device			
back bend			
back support / brace			
chiropractic care			
cold (ice pack)			
exercise			
foam rolling			
heat			
icy/hot cream			
knee to chest			
lying on back			
lying on side (right or left)			
massage			
medication			
movement			
popping back			
popping neck			
resting			
running			
sitting			
sleeping			
standing			
stretching			
TEN's unit			
upright posture			
Walking			
warm bath			
warm car seat			
warm shower			
yoga			
nothing			
Other:			

- **Is the symptom worse at certain times of the day or night?**

  □ No difference □ Morning □ Afternoon □ Evening □ Night □ As the day progresses Other: _____

- **What percentage of the time do you experience the above symptom (s):**

  0 - 5 - 10 - 15 - 20 - 25 - 30 - 35 - 40 - 45 - 50 - 55 - 60 - 65 - 70 - 75 - 80 - 85 - 90 - 95 - 100

- **Pain with movement?**

Back	□ bending forward	□ bending back	□ bending right	□ bending left	□ rotating right	□ rotating left
Neck	□ bending forward	□ bending back	□ tilting right	□ tilting left	□ rotating right	□ rotating left

- **Does symptom radiate to another part of your body?** □ yes □ no

  If yes, where does the symptom radiate? _____

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