360 Wellness
AZ CHIROPRACTIC | PMMTP

Patient Initial Intake Form

Patient Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell #: _____ Home #: _____ Work #: _____

We use text messaging for appointment reminders. Who is your cel phone carrier? _____

Email address: _____ SS# _____

Date of Birth: _____ Occupation: _____

Single: Yes/No Spouse Name: _____ # of Children _____

Employer Name: _____

Employer Address: _____

Reason for being seen: _____

_____

Insurance Company Name _____ Do you have HSA Flex account Yes / No Amount? $_____

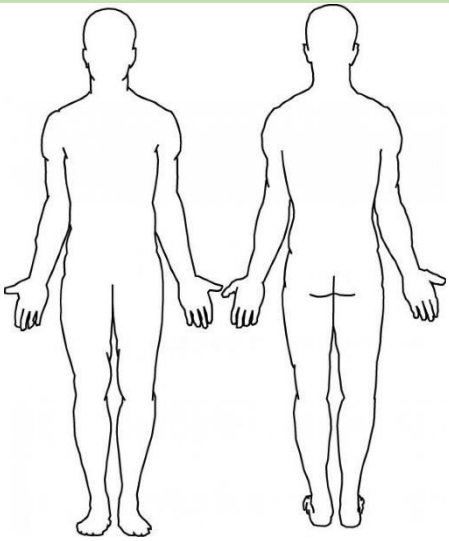
Have you seen a Chiropractor before? Yes / No DC name: _____ When? _____

Who may we thank for referring you to our office? _____

Chief Complaint: _____ Date Started: _____

Have you been in a car accident recently? Yes / No Date of Accident: _____

Please mark an X on the diagrams below to indicate where your pain is.



What is your level of pain? **Circle one:** 1 2 3 4 5 6 7 8 9 10

No Pain Mild Pain Moderate Pain Severe Pain Extreme Pain

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Is your pain present **infrequently 0-25%** of the time? Yes / No
Is your pain present **intermittently 26-50%** of the time? Yes / No
Is your pain present **frequently 50-75%** of the time? Yes / No
Is your pain present **constantly 76-100%** of the time? Yes / No

Please ☑ check all symptoms you have ever had, even if they seem unrelated to your problem.

- ☐ Neck Pain
- ☐ Headaches
- ☐ Neck Stiffness
- ☐ Pins and Needles in Arms
- ☐ Numbness in Fingers
- ☐ Loss of Smell
- ☐ Dizziness
- ☐ Fatigue
- ☐ Difficulty Swallowing
- ☐ Buzzing/Ringing in Ears
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Lights Bothers Eyes
- ☐ Upper Back Pain
- ☐ Pain between Scapulae
- ☐ Shoulder Pain Rt/Lt/Bi
- ☐ Numbness in Toes
- ☐ Currently Pregnant
- ☐ Cold Sweats
- ☐ Irritability
- ☐ Depression
- ☐ Nervousness
- ☐ Cancer _____
- ☐ Muscle Spasm
- ☐ Cold Hands / Feet
- ☐ Tension
- ☐ Low Back Pain
- ☐ Pain in Buttocks
- ☐ Pain in Legs Rt/Lt/Bi
- ☐ Numbness in Feet
- ☐ Loss of Balance
- ☐ Difficulty Sleeping
- ☐ Menstrual Pain
- ☐ Irregular Periods
- ☐ Loss of Sexual Function
- ☐ Hot Flashes
- ☐ Weight Loss/Gain
- ☐ Lack of Appetite/Taste
- ☐ Fever
- ☐ Heart Problems
- ☐ Hypertension
- ☐ Stroke
- ☐ Asthma / COPD
- ☐ COVID 19
- ☐ Diabetes Type1/Type 2
- ☐ Urination Problems
- ☐ Constipation/Diarrhea
- ☐ Heartburn
- ☐ Upset Stomach
- ☐ Fainting
- ☐ Upset Stomach
- ☐ Ulcer

List any medications you are taking: _____

List any vitamins/supplements you are taking: _____

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial here _____ that you have been made aware of this availability. The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and treatment.

Patient Signature: X_____ Date: _____

I, allow 360 Wellness to bill my insurance and give them permission to accept assignment of benefits on my behalf.

Patient Signature: X_____-_____ Date: _____

----------For Guardian's Only----------

I, give permission to this office to allow minor child _____ to be examined and/or receive treatment.
(minor child's name)

Guardian Signature: X_____ Date: _____