Vissers Chiropractic

Michael Vissers, DC
130 SW 2nd Avenue, Suite 101 Canby, OR 97013 (503) 263-3033

New Patient Intake

Name:_____ Preferred Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Male / Female Age:_____ Date of Birth:_____ Marital Status: M, S, D, W

Home Phone:_____ Email Address:_____

Cell Phone:_____ Would you like to receive text reminders for appts? Y N

Serv Prov (circle one): AT&T – Boost – Cricket – Metro PCS – Nextel – Sprint – T-Mobile – US Cellular – Verizon - Virgin

Employer:_____ Occupation:_____

Work Address:_____ Wk Ph:_____

Spouse's Name:_____ Birth Date:_____

Spouse's Employer:_____ Wk Ph:_____

Health Insurance Coverage:_____ Insured's Name:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Prim Care Physician:_____ How did you hear about our office?_____

Reason for today's visit: ☐ Pain Relief ☐ Auto / Work Injury ☐ Rehab Instruction ☐ Other _____

Medical History Please check all of the following that apply to you: None apply ☐

No	Yes	Condition	No	Yes	Condition
☐	☐	Recent Trauma	☐	☐	Birth Control Pills
☐	☐	Recent Fever / Infection	☐	☐	Pregnancy, # of births _____
☐	☐	Sleep Apnea / CPAP	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Diabetes	☐	☐	Urinary Retention
☐	☐	High Blood Pressure	☐	☐	Frequent Urination
☐	☐	Heart Disease	☐	☐	Prostate Problems
☐	☐	Stroke (date) _____	☐	☐	Visual Disturbances
☐	☐	Aortic Aneurysm	☐	☐	Dizziness / Fainting
☐	☐	Epilepsy / Seizures	☐	☐	Corticosteroid Use
☐	☐	Arthritis	☐	☐	History of Alcohol Use
☐	☐	Osteoporosis	☐	☐	History of Tobacco Use
☐	☐	Cancer / Tumor	☐	☐	History of Neck Pain
☐	☐	HIV / AIDS	☐	☐	History of Mid / Low Back Pain
☐	☐	Surgeries (list) _____			
☐	☐	Medications (list) _____			
☐	☐	X-Rays, MRI, CT SCAN (list) _____			

Family History of: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate to the best of my knowledge. I hereby authorize this office and its Doctor to administer care to me as they deem necessary. I assign directly to Vissers Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature: _____ Date: _____

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Patient Symptom Form – Initial

Name_____ **Date**_____

Complaint	Area #1	Area #2	Area #3
How are you feeling today? 0 = no pain thru 10 = much pain			
Does the pain travel anywhere? Where?			
Date pain began?			
How did the pain begin?			
How often does it hurt?			
What makes the pain worse?			
What makes the pain less?			
What can't you do that you did before the pain started?			
Have you tried anything at home to relieve the pain?			
Have you seen any other Doctors for it? Who? When?			
What did Doctors Advise?			
Have you had this pain before? When?			

Pain Drawing

Please indicate the location of pain and the symbol that best describes the discomfort you are feeling.

Type of Pain	Symbol
Sharp / Stabbing	+++++++
Dull / Achy	VVVV
Pins / Needles	OOOOO
Numbness	/ / / / /