



# CONFIDENTIAL NEW PATIENT INTAKE FORM

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**DR. RENEE BONAREK**  
Doctor of Chiropractic  
Certified Acupuncturist  
(708) 625 - 6652  
[DrRenee@yahoo.com](mailto:DrRenee@yahoo.com)

\_\_\_\_\_  
TODAY'S DATE (MM/DD/YYYY)

\_\_\_\_\_  
LAST NAME FIRST NAME BIRTH DATE (MM/DD/YYYY)

\_\_\_\_\_  
ADDRESS CITY STATE ZIP CODE

\_\_\_\_\_  
CELL PHONE HOME PHONE EMAIL ADDRESS

**GENDER**                      **MARITAL STATUS**                      **HAVE YOU CONSULTED A CHIROPRACTOR BEFORE?**  
 MALE                       SINGLE     DIVORCED     SEPARATED                       YES When? \_\_\_\_\_  
 FEMALE                       MARRIED     WIDOWED                       NO

\_\_\_\_\_  
EMERGENCY CONTACT EMERGENCY CONTACT PHONE RELATIONSHIP TO EMERGENCY CONTACT

\_\_\_\_\_  
OCCUPATION EMPLOYER

\_\_\_\_\_  
PRIMARY CARE PROVIDER'S NAME PRIMARY CARE PROVIDER'S PHONE

\_\_\_\_\_  
INSURANCE CARRIER (Put N/A if you will not be using insurance) POLICY NUMBER GROUP NUMBER

\_\_\_\_\_  
POLICY HOLDER'S LAST NAME POLICY HOLDER'S FIRST NAME BIRTH DATE (MM/DD/YYYY)

\_\_\_\_\_  
RELATIONSHIP TO POLICY HOLDER POLICY HOLDER'S EMPLOYER

- 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 or professional services rendered to me will be immediately due and payable.
- I will be paying with cash for my care/treatment, therefore billing insurance is not necessary at this time. 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 or professional services rendered to me will be immediately due and payable.

\_\_\_\_\_  
SIGNATURE DATE

**PRIMARY COMPLAINT**

The primary symptom that prompted me to seek care today is:

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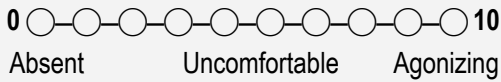
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**Intensity** (How extreme are your symptoms?)



**My symptom is a result of:**

- An accident or injury  
 Work  Auto  Other
- A worsening long-term problem
- An interest in:  Wellness  Other

**Onset** (When did you first notice your current symptoms?)

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**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture
- Over-the-counter drugs  Chiropractic
- Homeopathic remedies  Massage
- Physical therapy  Ice
- Surgery  Heat
- Other \_\_\_\_\_

**Duration and Timing** (How often do you feel it?)

- Constant  Comes and goes. How often?

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**Quality of symptoms** (What does it feel like?)

- Numbness  Aching  Burning
- Tingling  Cramps  Shooting
- Stiffness  Nagging  Throbbing
- Dull  Sharp  Stabbing
- Other \_\_\_\_\_

**How does your current condition interfere with your:**

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

**SECONDARY COMPLAINT**

The secondary symptom that prompted me to seek care today is:

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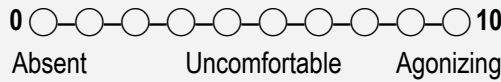
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**Intensity** (How extreme are your symptoms?)



**My symptom is a result of:**

- An accident or injury  
 Work  Auto  Other
- A worsening long-term problem
- An interest in:  Wellness  Other

**Onset** (When did you first notice your current symptoms?)

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**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture
- Over-the-counter drugs  Chiropractic
- Homeopathic remedies  Massage
- Physical therapy  Ice
- Surgery  Heat
- Other \_\_\_\_\_

**Duration and Timing** (How often do you feel it?)

- Constant  Comes and goes. How often?

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**Quality of symptoms** (What does it feel like?)

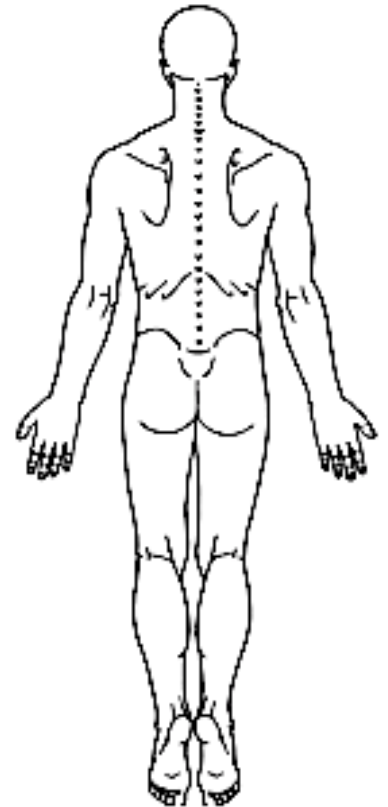
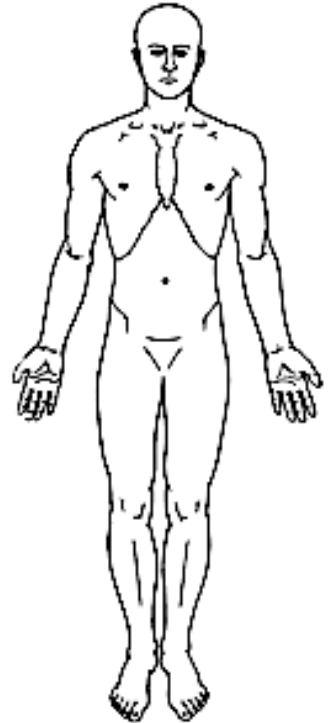
- Numbness  Aching  Burning
- Tingling  Cramps  Shooting
- Stiffness  Nagging  Throbbing
- Dull  Sharp  Stabbing
- Other \_\_\_\_\_

**LOCATION**

(Where does it hurt?)

Circle the area(s) on the illustration below.

“O” for current condition  
“X” for conditions experienced in the past



## Review of Symptoms

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please ONLY darken the circle beside any condition that you have HAD or currently HAVE.

**HAD HAVE**

- Arthritis
- Back Problems
- Elbow/Wrist Pain
- Foot/Ankle Pain
- Hip Disorders
- Knee Injuries
- Neck Pain
- Osteoporosis
- Poor Posture
- Scoliosis
- Shoulder Problems
- TMJ Issues
- Anxiety
- Depression
- Dizziness
- Headache

**HAD HAVE**

- Numbness
- Pins and Needles
- Low Energy
- Fainting
- Weakness
- Poor Appetite
- Fatigue
- Asthma
- Shortness of Breath
- High Blood Pressure
- Low Blood Pressure
- High Cholesterol
- Poor Circulation
- Excessive Bruising
- Constipation
- Diarrhea

**HAD HAVE**

- Thyroid Issues
- Immune Disorders
- Frequent Infection
- Swollen Glands
- Kidney Stones
- Infertility
- Prostate Issues
- PMS Symptoms
- Sudden Weight Loss
- Sudden Weight Gain
- Blurred Vision
- Ringing in Ears
- Hearing Loss
- Chronic Ear Infection
- Loss of Smell
- Loss of Taste

## Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering/bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing self	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is there anything else you would like Dr. Renee to know about your current condition?

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