

**SIGNATURE** 

# CONFIDENTIAL NEW PATIENT INTAKE FORM

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#### DR. RENEE BONAREK

Doctor of Chiropractic Certified Acupuncturist (708) 625 - 6652 DrRenee@yahoo.com

TODAY'S	S DATE (MM/DD/Y	YYY)								
LAST NAME			FIR	FIRST NAME			BIRTH DATE (MM/DD/YYYY)			
ADDRES	SS			CITY			STATE	ZIP CODE		
CELL PH	HONE		HOME PHON	E		EMAIL	ADDRES	S		
GENDER MARITAL STATUS  MALE SINGLE DIVORCED  FEMALE MARRIED WIDOWED			$\sim$	PARATED		HAVE YOU CONSULTED A CHIROPRACTOR YES When? NO				
EMERG	ENCY CONTACT			EMER	GENCY CONTAC	CT PHONE	RELA	ATIONSHIP TO EMERGENCY CONTACT		
OCCUPA	ATION				EMPLOYER					
PRIMAR	Y CARE PROVIDE	R'S NAME			PRIMAI	RY CARE PRO	OVIDER'S	S PHONE		
INSURA	NCE CARRIER (Po	ıt N/A if you will no	ot be using insura	nce)	POLICY NUM	IBER		GROUP NUMBER		
POLICY HOLDER'S LAST NAME POLICE				LICY HOLDE	CY HOLDER'S FIRST NAME			BIRTH DATE (MM/DD/YYYY)		
RELATIO	ONSHIP TO POLIC	Y HOLDER	PO	LICY HOLDE	ER'S EMPLOYER	R				
$\bigcirc$		ices rendered to r	ne and charged a	re my persor	nal responsibility f	or timely paym	nent. I un	carrier and myself. I understand and derstand that if I suspend or terminate my		
$\bigcirc$	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.									

DATE

PRIMARY COMPLAINT The primary symptom that prompted me to seek care today is:	SECONDARY COMPLAINT The secondary symptom that prompted me to seek care today is:	LOCATION (Where does it hurt?) Circle the area(s) on the illustration below. "O" for current condition "X" for conditions experienced in the past		
Intensity (How extreme are your symptoms?)  0	Intensity (How extreme are your symptoms?)  0			
Prior interventions (What have you done to relieve the symptoms?)  Prescription medication Over-the-counter drugs Chiropractic Homeopathic remedies Massage Physical therapy Ice Surgery Heat Other  Duration and Timing (How often do you feel it?)	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?  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 y	Constant Comes and goes. How often?  Quality of symptoms (What does it feel like?)  Numbness Aching Burning  Tingling Cramps Shooting  Stiffness Nagging Throbbing  Dull Sharp Stabbing  Other			
Work or career:		-G1 1.95		
Recreational activities:				
mousenoid responsibilities:				

### **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		HAD	HAVE	HAD HAVE				
$\bigcirc$	$\bigcirc$	Arthritis	$\bigcirc$	$\bigcirc$	Numbness	$\bigcirc$	$\bigcirc$	Thyroid Issues
$\bigcirc$	$\bigcirc$	Back Problems	$\bigcirc$	$\bigcirc$	Pins and Needles	$\bigcirc$	$\bigcirc$	Immune Disorders
$\bigcirc$	$\bigcirc$	Elbow/Wrist Pain	$\bigcirc$	$\bigcirc$	Low Energy	$\bigcirc$	$\bigcirc$	Frequent Infection
$\bigcirc$	$\bigcirc$	Foot/Ankle Pain	$\bigcirc$	$\bigcirc$	Fainting	$\bigcirc$	$\bigcirc$	Swollen Glands
$\bigcirc$	$\bigcirc$	Hip Disorders	$\bigcirc$	$\bigcirc$	Weakness	$\bigcirc$	$\bigcirc$	Kidney Stones
$\bigcirc$	$\bigcirc$	Knee Injuries	$\bigcirc$	$\bigcirc$	Poor Appetite	$\bigcirc$	$\bigcirc$	Infertility
$\bigcirc$	$\bigcirc$	Neck Pain	$\bigcirc$	$\bigcirc$	Fatigue	$\bigcirc$	$\bigcirc$	Prostate Issues
$\bigcirc$	$\bigcirc$	Osteoporosis	$\bigcirc$	$\bigcirc$	Asthma	$\bigcirc$	$\bigcirc$	PMS Symptoms
$\bigcirc$	$\bigcirc$	Poor Posture	$\bigcirc$	$\bigcirc$	Shortness of Breath	$\bigcirc$	$\bigcirc$	Sudden Weight Loss
$\bigcirc$	$\bigcirc$	Scoliosis	$\bigcirc$	$\bigcirc$	High Blood Pressure	$\bigcirc$	$\bigcirc$	Sudden Weight Gain
$\bigcirc$	$\bigcirc$	Shoulder Problems	$\bigcirc$	$\bigcirc$	Low Blood Pressure	$\bigcirc$	$\bigcirc$	Blurred Vision
$\bigcirc$	$\bigcirc$	TMJ Issues	$\bigcirc$	$\bigcirc$	High Cholesterol	$\bigcirc$	$\bigcirc$	Ringing in Ears
$\bigcirc$	$\bigcirc$	Anxiety	$\bigcirc$	$\bigcirc$	Poor Circulation	$\bigcirc$	$\bigcirc$	Hearing Loss
$\bigcirc$	$\bigcirc$	Depression	$\bigcirc$	$\bigcirc$	Excessive Bruising	$\bigcirc$	$\bigcirc$	Chronic Ear Infection
$\bigcirc$	$\bigcirc$	Dizziness	$\bigcirc$	$\bigcirc$	Constipation	$\bigcirc$	$\bigcirc$	Loss of Smell
$\bigcirc$	$\bigcirc$	Headache	$\bigcirc$	$\bigcirc$	Diarrhea	$\bigcirc$	$\bigcirc$	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		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting  Rising out of chair  Standing  Walking  Lying down  Bending over  Climbing stairs  Using a computer  Getting in/out of a car  Driving a car  Looking over shoulder  Caring for family		_		9999999999	Grocery Shopping ————————————————————————————————————				200000000000000000000000000000000000000
Is there anything else you	would like	Dr. Renee	to know abou	ut your cui	rent condition?				

## Personal, Social, and Family History

Please identify your past and current health history, in addition to your health habits and family health history.

	Illnesses		Allergies		Treatments		
	HAD HAVE		Please list ANY medication	ons that you are allergic to:	Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> .		
	$\bigcirc$	AIDS			the Fast of are receiving Currently.		
	$\bigcirc$	Alcoholism			Past Current		
	$\bigcirc$	Allergies			Acupuncture		
	$\circ$	Arteriosclerosis			Antibiotics		
	$\bigcirc$	Cancer	Injuries		Birth control pills		
	000000000000000000000000000000000000000	Chicken Pox	Have you ever		Blood transfusions Chemotherapy Dialysis Herbs Homeopathy Inhaler		
	$\check{\cap}$	Diabetes	Had a broken or fract	ured bone?			
	$\sim$	Epilepsy	Had a spine or nerve	disorder?			
	$\mathcal{A}$	Glaucoma	Been knocked uncon	scious?			
		Goiter	Been injured in an ac	cident?			
	$\times$		Used a crutch or other				
		Gout	Used neck or back br	• •			
PERSONAL	$\bigcirc$	Heart Disease	O COOC HOOK OF BUCK BI	0 0			
ō	$\bigcirc$	Hepatitis	Operations		Massage therapy		
RS	$\bigcirc$	HIV Positive	Surgical interventions, wh	ich may or may not have	Physical therapy		
H	$\circ$	Malaria	included hospitalization.		Medications (Please list below all prescription, over- the-counter, natural supplements,		
	$\circ$	Measles	Appendix removal				
	$\overline{\bigcirc}$	Multiple Sclerosis	Bypass surgery				
	$\tilde{\cap}$	Mumps	Cancer		enzymes, vitamins and minerals):		
	$\tilde{\bigcirc}$	Polio	Cosmetic surgery				
	$\mathcal{A}$	Rheumatic Fever	Elective surgery:				
	$\times$	Scarlet Fever					
			Eye surgery				
		Sexually Transmitted Disease	Hysterectomy				
		Stroke	Pacemaker				
	000000000	Tuberculosis	Spine:				
		Thyroid Fever	Tonsillectomy				
	$\bigcirc$	Ulcer	Vasectomy				
	$\bigcirc$	Other:	Other :				
	Alcohol use	O Daily	Weekly Month	lly How much?			
	Coffee use	O Daily	Weekly Month	•			
	Tobacco use	Daily	Weekly Month	•			
SOCIAL	Exercise	Daily	Weekly Month	•			
$\overline{\mathbf{z}}$	Pain relievers	Daily	Weekly Month	•			
S	Soft drinks	Daily	Weekly Month	•			
		$\simeq$ .	~ ~	•			
	Water intake	Daily	Weekly Month	•			
	Recreational d	rugs Daily	Weekly Month	lly How much?			
	Polativo(a) *a	NLY list those family members with the fo	ouing hoolth condition-1	Past / Current H	loalth leeuse		
	Relative(S) "Of	NLY list those family members with the fo	•				
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			Musculoske	letal Problems	Disease Cancer Diabetes		