Paramount Chiropractic & Wellness
1201 Richardson Drive, Suite 130
Richardson, Tx 75080
T: 214-613-2989

Patient Intake Form
Please fill out and email back to:
PCWgonstead@gmail.com

Date:_____

CONTACT INFORMATION

Name: _____ Birth Date: _____ □ Male □ Female

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Whom may we thank for referring you: _____

Primary Doctor: _____ Marital Status: **S M D W** Spouse's Name: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Occupation: _____ Employer: _____

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? □Yes □ No

If yes, doctor's name: _____

Date of last chiropractic visit: _____ Reason for care: _____

Date of last chiropractic x-rays: _____ How long were you under care: _____

ACCIDENT INFORMATION

Is this condition due to an accident: □ Yes □ No

Type of accident: □ Auto □ Work □ Home □ Other _____

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Check box to indicate if you have had any of the following:

- □ Headaches/Migraines
- □ Dizziness or light-headed
- □ Jaw pain/clicking/ locking
- □ Neck pain or stiffness
- □ Shoulder pain
- □ Mid back pain
- □ Chest pain or cough
- □ Arm/hand numbness/ tingling
- □ Arm/hand fatigue/ weakness
- □ Low back pain/Sciatica
- □ Leg/foot numbness/ tingling
- □ Leg/foot fatigue/ weakness
- □ Leg pain with walking
- □ Sensitive to light
- □ Sensitive to sound
- □ Visual problems
- □ Hearing problems
- □ Memory loss/problems
- □ Irritability or depression
- □ Fatigue or loss of energy
- □ Trouble with balance or coordination
- □ Sleep problems
- □ Rashes (face, body, limbs)
- □ Joint pain or swelling
- □ Pain with exertion i.e. activity, climbing stairs
- □ Chronic Sinus
- □ Ear Infections
- □ Allergies
- □ Asthma
- □ Difficulty Breathing
- □ Kidney problems
- □ Digestion problems
- □ Poor circulation
- □ Bladder problems
- □ Prostate problems
- □ Thyroid problems
- □ Alcohol/Drug Abuse
- □ AIDS/HIV
- □ Epilepsy/ Fainting/Seizures
- □ Osteoporosis
- □ Osteo Arthritis/ Rheumatoid Arthritis
- □ Heart Attack/Stroke
- □ Heart Defect/Condition
- □ Heart Surgery/Pacemaker
- □ High Cholesterol
- □ Low/High blood pressure
- □ Diabetes Type 1/Type II
- □ Shingles
- □ Cancer/Chemotherapy
- □ Venereal disease
- □ Hepatitis
- □ Ulcers/Colitis/IBS
- □ Artificial Bones/Joints
- □ Abnormal menstrual cycle

Do you smoke: □No □Yes How much: _____ How long: _____

Are you wearing: □ Heel lifts □ Arch Supports □ Other Supports

List ***all medications/supplements/controlled substances*** you are taking. List ***any medication*** allergies:

_____

List all surgical operations and years: _____

List all serious accidents with dates: (motor vehicle accidents, falls, spills or broken bones): _____

_____

Are you pregnant: □Yes □ No

Expected Delivery Date: _____

CURRENT HEALTH CONDITION

What is your major complaint: _____

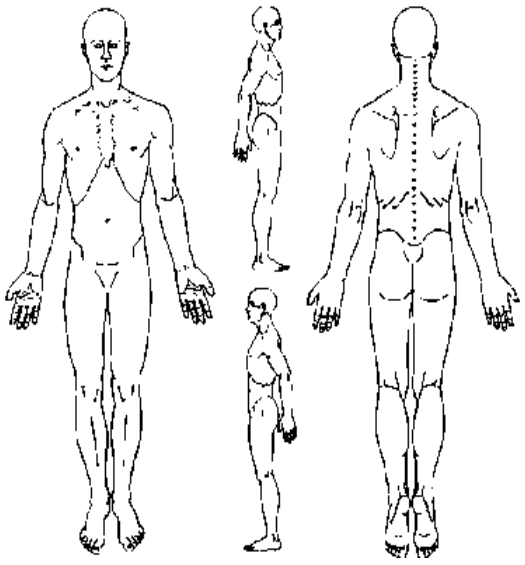
How long have you had this condition: _____

Have you had this or similar conditions in the past: _____

What activities aggravate your condition: _____

Is this condition getting progressively worse: □Yes □ No

□ Constant □ Comes and goes



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Is this condition interfering with your:

□ Work □ Sleep □ Daily Routine □ Other: _____

Other doctors who treated this condition: _____

Do you exercise regularly? N/Y If Yes, what is your main routine?

_____

What is your diet/food intake like? (vegan, vegetarian, keto, carnivore, high carb, fast):

_____

*Please let us know about anything else you think may be impacting your health or related to your pain/injury. Your Doctor (D.C.) will consult with you thoroughly/in detail about it.

_____
_____
_____
_____
_____

I _____ Give Paramount Chiropractic & Wellness and any of its subsidiaries to consult and examine me upon signing this document.

Signature of Patient: _____ Date: _____