Boen Chiropractic, L.L.C.
Christe M. Boen, D.C., C.C.S.P.
115 Clarkson Executive Park
Ellisville, MO 63011
636-386-5900

PATIENT INTAKE FORM

Date: ____________

PATIENT INFORMATION – Please Print

Patient Name (First, MI, Last): ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: ____________

Phone (cell): ____________________ Phone (home): ____________________

Email: ____________________ Birthdate: ____________ Age: ______

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ____________________ Employer/School: ____________________

Spouse's Name: ____________________ Spouse's Birthdate: ____________

EMERGENCY CONTACT: ______________________________

Relationship to Patient: ____________ Phone: ____________________

Whom may we thank for referring you to us? ______________________________

INSURANCE INFORMATION

Who is responsible for this account? ____________________ Relationship to Patient: ____________

Mailing Address (if different from above): ______________________________

Insurance Company: ____________________ **OFFICE USE ONLY:** ☐ In Network ☐ Out of Network

PATIENT CONDITION

Reason for Visit: ______________________________

When did your symptoms appear? ______________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure

Rate the severity of your pain today on a scale from 1 (least pain) to 10 (severe pain): ____________

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Swelling ☐ Other: ____________

How often do you have this pain? ______________________________

Is the pain constant or does it come and go? ☐ Constant ☐ Comes and goes

Which of the following does the pain interfere with? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Which of these are painful to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What treatment have you already received for your condition? ☐ None ☐ Medication ☐ Surgery

☐ Physical Therapy ☐ Chiropractic Services ☐ Other: ____________________

Which of the following have you had done related to this condition? ☐ X-Ray ☐ MRI ☐ Ultrasound

☐ Other: ______________________________

HEALTH HISTORY

Please check any of the following that you have ever had:

☐ AIDS/HIV	☐ COVID	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Diabetes	☐ Measles	☐ Rheumatic Fever
☐ Allergy Shots	☐ Emphysema	☐ Migraine Headaches	☐ Scarlet Fever
☐ Anemia	☐ Epilepsy	☐ Miscarriage	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Mononucleosis	☐ Suicide Attempt
☐ Appendicitis	☐ Glaucoma	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Arthritis	☐ Goiter	☐ Mumps	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Osteoporosis	☐ Tuberculosis
☐ Bleeding Disorders	☐ Gout	☐ Pacemaker	☐ Tumors/Growths
☐ Breast Lump	☐ Heart Disease	☐ Parkinson's Disease	☐ Typhoid Fever
☐ Bronchitis	☐ Hepatitis	☐ Pinched Nerve	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cancer	☐ Herniated Disk	☐ Polio	☐ Venereal Disease
☐ Cataracts	☐ Herpes	☐ Prostate Problems	☐ Whooping Cough
☐ Chemical Dependency	☐ High Cholesterol	☐ Prosthesis	☐ Other: ___________
☐ Chicken Pox	☐ Kidney Disease	☐ Psychiatric Care	____________________

Are you pregnant? ☐ Yes ☐ No If so, what is your due date? ______________________

EXERCISE LEVEL: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS: ☐ Smoking Packs/Day _____ ☐ Coffee/Caffeine Drinks Cups/Day _____

☐ Alcohol Drinks/Week _____ ☐ High Stress Level Reason ____________________

PAST INJURIES/SURGERIES

	Description	Date
Falls	______________________________	____________
Head Injuries	______________________________	____________
Broken Bones	______________________________	____________
Dislocations	______________________________	____________
Surgeries	______________________________	____________

ALLERGIES

____

MEDICATIONS

____

VITAMINS/MINERALS/HERBS

____