Keystone Chiropractic, LLC
Brad Vollmer, DC

685 Portland Avenue
Gladstone, Oregon 97027

P: 503.908.1001 / F: 503.908.1002
keystonechiropracticpdx.com

New Patient Intake Form

Patient Name: _____ Date: _____

Date of Birth: _____ Date of Injury: _____ ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ SEP

Mark (C) for current problems, check (☑) and indicate the age when you had any of the following:

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulitis
- ☐ Bloated Abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defecation
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting and blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24 hours
- ☐ Decreased flow / forced
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over the heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow:____ Length of cycle_____
Date - 1st day last period: _____
Are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ Normal ☐ Abnormal
Date of last mammogram: _____
☐ Normal ☐ Abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness / tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications with dosages you are currently taking and why:

_____

_____

_____

Signature: _____ **Date:** _____

Keystone Chiropractic, LLC
Brad Vollmer, DC
685 Portland Avenue
Gladstone, Oregon 97027
P: 503.908.1001 / F: 503.908.1002
keystonechiropracticpdx.com

New Patient Intake Form (page 2)

Patient Name: _____ Date: _____
Date of Birth: _____ Date of Injury: _____

Chief Complaint History:
Please give a brief detailed description of the problem you are currently experiencing: _____
_____
What seemed to be the initial cause? _____
_____
How long have you had this condition? _____ Is the condition getting: ☐ Better ☐Same ☐ Worse _____
Does it bother you: ☐ Constantly (24 hours/day) _____ ☐ Comes and goes _____
If it comes and goes: How often? _____x per day/week/month How long do the symptoms last? _____ min/hr _____
Describe the pain or symptoms (sharp, dull, etc.): _____
Do you have night pain? ☐ Yes ☐ No Does it prevent you from sleeping?(cannot find a comfortable position) ☐ Yes ☐ No
Does it bother your (check appropriate boxes): ☐ work ☐ sleep ☐ hobbies ☐ Other: _____
What makes it better? _____
What makes it worse? _____
Prior medical treatment: ☐ Yes ☐ No If yes, where? _____
When? _____ Did treatment help? ☐ Yes ☐ No _____
Given medication? ☐ Yes ☐ No _____
Did this help? ☐ Yes ☐ No _____ X-rays/CT/MRI obtained: ☐ Yes ☐ No Other tests? _____

Have you been experiencing: Bowel/Bladder changes: ☐ Yes ☐ No If yes, describe: _____
Numbness/Tingling/Weakness/Pain into extremities: ☐ Yes ☐ No If yes, describe: _____
_____
Tinnitus (ringing in the ears): ☐ Yes ☐ No If yes, L / R / Both Memory problems: ☐ Yes ☐ No Concentration problems: ☐ Yes ☐No
Vision changes: ☐ Yes ☐ No If yes, describe: _____ Dizziness: ☐ Yes ☐ No Loss of balance: ☐ Yes ☐ No

Past Health History:

Have you...	Yes	No	If yes, explain briefly
...been hospitalized in the last 5 years?	☐	☐	_____
...had any major surgeries?	☐	☐	_____
...had any major illnesses?	☐	☐	_____
...had any previous auto injuries?	☐	☐	_____
...had any previous work injuries?	☐	☐	_____
...had any trauma (eg; broken bones)?	☐	☐	_____

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

How is most of your day spent? ☐ standing, ☐ sitting, ☐ driving, ☐ other: _____
When was your last physical exam? _____
Previous chiropractic care? ☐ Yes ☐ No If yes, describe (who, when, for what): _____
_____

Family History:
Have you or any blood relative has had any of the following conditions? Please check and indicate which relative(s)

☐ Alcoholism	☐ Cancer	☐ Diabetes
☐ High blood pressure	☐ High cholesterol	☐ Heart disease
☐ Stroke	☐ Arteriosclerosis	☐ Anemia
☐ Arthritis	☐ Emphysema	☐ Epilepsy
☐ Multiple sclerosis	☐ Thyroid disease	☐ Osteoporosis
☐ Glaucoma	☐ Bleed easily	☐ Asthma

Do you have any other health issues or concerns that our staff should be made aware of? _____
_____
Do you have any other health goals you would like us to help you with? _____

Signature: _____ **Date:** _____

Keystone Chiropractic, LLC
Brad Vollmer, DC

685 Portland Avenue
Gladstone, Oregon 97027

P: 503.908.1001 / F: 503.908.1002
keystonechiropracticpdx.com

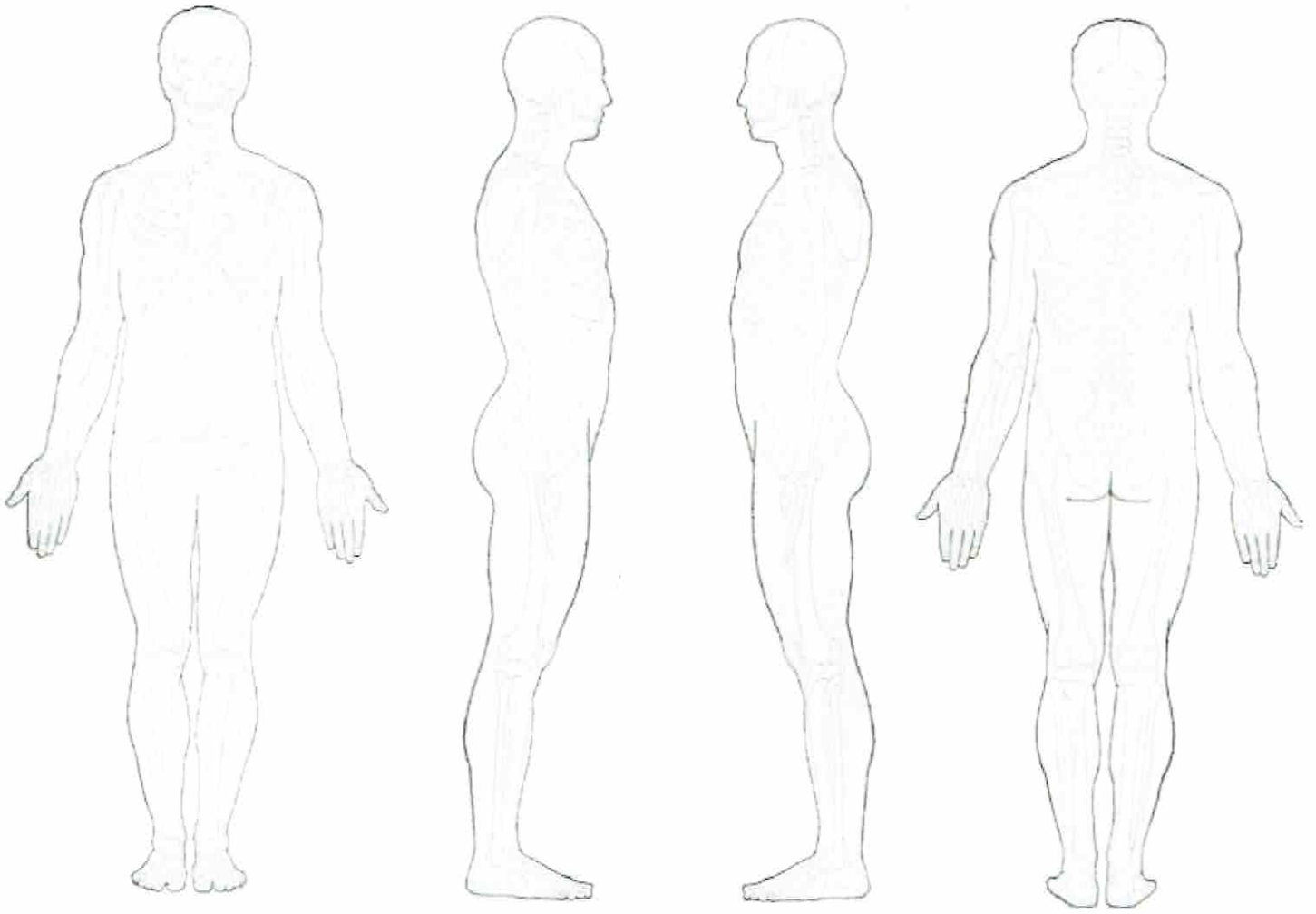
New Patient Intake Form

Patient Name: _____ Date: _____

Date of Birth: _____ Date of Injury: _____

Please mark your symptoms on the body diagram below.

Circle the areas of pain **N** - areas of numbness **T** - areas of tingling **W** - areas of weakness



Please place a mark at the level of your pain on the scale below: