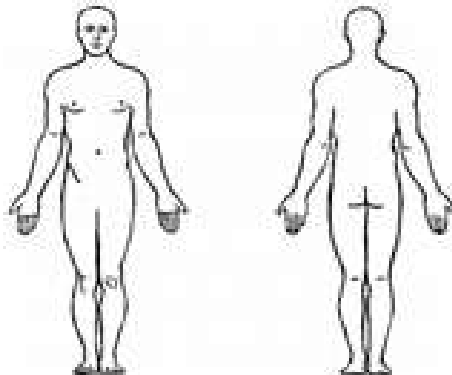


Hoffmann Chiropractic
310 Maple Ave L 04
Barrington RI 02806
401-289-2444
Fax: 1-866-744-5975

New Patient Intake Form

Name: _____ Date _____
DOB: _____ Address _____
Phone#: H _____ C _____ Email: _____
Social Security: _____ Occupation: _____
Referral: _____
Is this condition: Job related MVA Acute Chronic Other _____



Chief Complaint: _____
Rate Pain level: 0 1 2 3 4 5 6 7 8 9 10 (0-None 10-Very Severe Pain)

Other Complaints: _____
Rate Pain level: 0 1 2 3 4 5 6 7 8 9 10 (0-None 10-Very Severe Pain)

When did the pain begin: ___/___/___ Prior Treatment: _____

Frequency: Constant Frequent Occasional Intermittent Daily/Weekly

Quality: Dull Sharp Throbbing Burning Deep Aching Tingling
Stabbing Cramping Numbness Radiation Other _____

Aggravating: Sitting Standing Walking Bending Stooping Lifting
Sleeping Sneezing Coughing Straining Reaching Twisting
Looking up Looking down Movement Rest Lying Down
Driving Typing House Chores Exercises Other _____

Relieving Factors: Sitting Standing Lying Knees bent up Support
No movement Movement Heat Ice Analgesic cream
Exercise Adjustments Medication _____

Other Information:

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Health History

Other Diagnosis: _____

Cancer: _____

Recent blood work: _____

Surgeries: _____

Hospitalizations: _____

Exercise: _____

Nutritional Supplements: _____

Family History: _____

Primary Physician: _____

Other Physicians: _____

Your signature below will verify that all information you have given is accurate and complete.

Patient Signature: _____ Date: _____