PATIENT INTAKE FORM

DR. CHARLES L. LENNON, III

PERSONAL INFORMATION

DATE: _____/_____/_____

FIRST NAME: _____ MID INT: ___ LAST NAME: _____ HEIGHT : _____
WEIGHT : _____

ADDRESS : _____ APT / UNIT # _____

CITY : _____ STATE : _____ ZIP : _____

BIRTHDATE : _____/_____/_____ SSN : _____ SEX : _____ M _____ F

TELEPHONE : Home _____ Mobile _____

EMAIL ADDRESS : _____ CAN WE EMAIL: APPOINTMENTS YES NO
BILLS YES NO

IN CASE OF EMERGENCY

NAME : _____ PHONE # _____ RELATIONSHIP : _____

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR ? _____ YES _____ NO

NAME : _____ PHONE # _____ LAST VISIT : _____

ADDRESS : _____ CITY : _____ STATE : _____ ZIP : _____

ALLERGIES : _____ ARE YOU MAKING A CLAIM FOR 1. RECENT MOTOR VEHICLE ACCIDENT YES NO
2. WORK RELATED INJURY YES NO

CHIROPRACTIC INFORMATION

REASON FOR SEEKING CHIROPRACTIC CARE TODAY?

_____

HOW LONG HAVE YOU BEEN SUFFERING WITH THIS CONDITION?

_____

HAVE YOU SOUGHT TREATMENT FROM A MEDICAL DOCTOR? YES NO

IF YES, WHAT TREATMENT WAS RECEIVED? _____

HAVE YOU HAD CHIROPRACTIC CARE IN THE PAST? YES NO

CHIROPRACTOR'S NAME : _____ LAST VISIT : _____

REASON FOR SEEKING CARE : _____ RESULTS: GOOD FAIR POOR

HEALTH INSURANCE

DO YOU HAVE HEALTH INSURANCE? YES NO

YOUR PLAN? YES NO
SPOUSE'S PLAN? YES NO DOB : _____
PARENT'S PLAN? YES NO DOB : _____

COMPANY NAME : _____

MEMBER ID# _____ INSURED NAME : _____

PATIENT INTAKE FORM

DR. CHARLES L. LENNON, III

GENERAL :
Loss of consciousness
Blackouts
Loss of sleep
Fever
Nervousness
Weight loss
Excess sweating
Night Sweats
Night pain
Generalized pain
Headaches
Convulsions

NEUROLOGIC:
Dizziness
Fainting
Blurred Vision
Double Vision
Nausea
Clumsiness
Numbness & Tingling

RESPIRATORY:
Asthma
Chronic cough
Difficulty breathing
Spitting up phlegm/blood

MUSCLES AND JOINTS:
Sore / Stiff neck
Mid back ache
Low back ache
Painful tailbone
Upper limb pain
Hip pain
Knee pain
Ankle / Foot trouble
Arthritis
Loss of strength

CARDIOVASCULAR:
Bleeding Disorder
High blood pressure
Chest pain
Stroke
Hardening of Arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart / Blood disease
Angina

GASTROINTESTINAL:
Poor appetite
Indigestion
Excess hunger
Excess belching / gas
Vomiting
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gallbladder trouble

URINARY:
Trouble urinating
Blood in urine
Kidney infections
Bedwetting
Prostate troubles
Menstruation issues
Breast swelling
Hot flashes

Have you ever been diagnosed with:

Cancer HIV / AIDS

Hep A / B / C

FAMILY HISTORY:
Cancer
Diabetes
Hypertension
Stroke

LIFESTYLE:

Smoking How much?

Alcohol use How much?

Exercise How much?

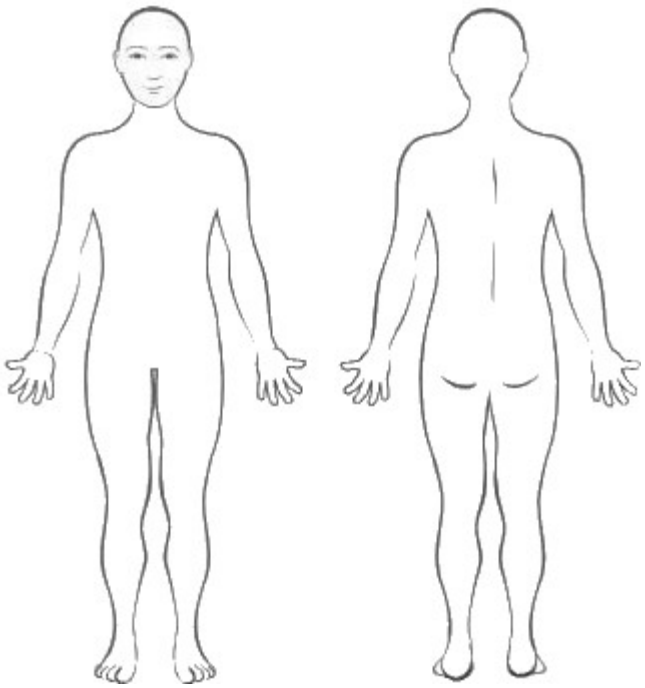
Healthy diet How much?

LIST ALL SURGERIES:

_____
_____
_____
_____
_____
_____

LIST ALL BROKEN / FRACTURED BONES:

_____
_____
_____
_____



HOW TO COMPLETE THIS DIAGRAM:

On the body drawn here, using the symbols below, please mark the location of your primary complaint and described sensation.

Ache	XXXXX
Burning	+++++
Numbness	^^^^^
Tingling	*****
Stabbing / Sharp	/ / / / /

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