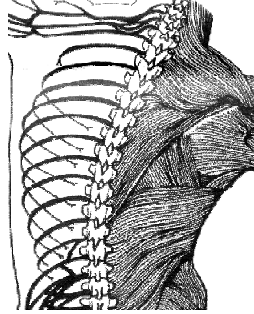

Dr. Andrea Buccino
Chiropractic Physician
6 Pompton Avenue
2nd Floor
Cedar Grove, NJ 07009
(973) 433-3655

Initial Intake Form:

NAME:____SOCSEC#____________

ADDRESS:____

CITY_________________________STATE__________ZIP____________________

HOME PHONE____________________________CELL PHONE________________

EMAIL ADDRESS____

M_____F_____AGE ___________DATE OF BIRTH__________________________

OCCUPATION_______________________MARITAL STATUS________________

SPOUSE'S NAME_____________________CHILDREN (number, and ages)__________

Person to be notified in case of an emergency:_________________________________
Phone number: ________________________
Relationship:__________________________

Name of Insured (if not self)____
DOB of Insured _________________________________Relation________________

Who may we thank for referring you?_______________________________________

NAME:_________________________________DATE________________________

PRESENT COMPLAINT:____

Did you go to the HOSPITAL/EMERGENCY ROOM for THIS CONDITION?

____NO if no, skip to the next section

____YES if yes, please continue

Name of facility:______________________________Location:_________________

Were you taken by ambulance?___________________________

Did you go immediately after the incident?__________________

Were x-rays taken?_________What area of the body?___________________________

What was the diagnosis?________________What was the treatment?______________

WHEN/HOW DID THIS START?____

- ❑ Immediately after a specific incident
- ❑ After multiple incidents
- ❑ Gradually, over time
- ❑ No specific reason

SINCE THE PROBLEM BEGAN, THE PAIN HAS:

- ❑ Increased
- ❑ Decreased
- ❑ Not changed

HOW OFTEN ARE THE COMPLAINTS PRESENT?

- ❑ Constantly (100%-76% of the time)
- ❑ Frequently (75%-51% of the time)
- ❑ Occasionally (50%-26% of the time)
- ❑ Intermittent (25%-0% of the time)

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE?______________

IF SO, WHAT TYPE OF TREATMENT, AND BY WHOM:_____________________

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE?__________________

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:

- ❑ Headache
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Jaw Pain
- ❑ Shoulder Pain
- ❑ Hand Pain
- ❑ Hip Pain
- ❑ Leg Pain
- ❑ Foot Pain
- ❑ Numbness in Fingers
- ❑ Numbness in Toes
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Joint Swelling
- ❑ Stiffness of Joints
- ❑ Fainting
- ❑ Loss of Consciousness
- ❑ Dizziness
- ❑ Seizures
- ❑ Nausea
- ❑ Balance Problems
- ❑ Chest Pains
- ❑ Shortness of Breath
- ❑ Loss of Appetite
- ❑ Inexplainable Weight Loss
- ❑ Night Sweats
- ❑ Pain Worse at Night
- ❑ Sleep Problems
- ❑ Excessive Thirst
- ❑ Frequent Urination
- ❑ Constipation
- ❑ Diarrhea
- ❑ Colitis/IBS
- ❑ Heartburn
- ❑ Ulcer
- ❑ Asthma
- ❑ Respiratory Problems
- ❑ Chronic Cough/Bronchitis
- ❑ Difficulty Swallowing
- ❑ Loss of Bladder Control
- ❑ Loss of Bowel Control
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Kidney Stones
- ❑ Arthritis
- ❑ Diabetes
- ❑ Cancer: ____________________
- ❑ Stroke: date_________________
- ❑ Heart Attack: date____________
- ❑ Bypass
- ❑ Pacemaker
- ❑ Metal Implants_______________
- ❑ Other Surgical Procedures___________________
  ____

Please list MEDICATIONS:____

Please list any Hospitalizations:____

How often do you use TOBACCO?: daily weekly monthly yearly
How often do you drink ALCOHOL? daily weekly monthly yearly
Do you EXERCISE? _______What type?_____________How often?_____________

FEMALES: Are you currently pregnant?________________
Do you use Birth Control Pills?_____________
Date of Last Menses_______________________