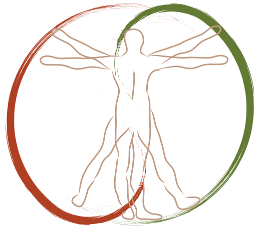



# DR. AMY KEMPFER

1207 Prairie Parkway West Fargo, ND 58078
Phone: 701.893.9100 | Text: 701.799.4362
docamydc@hotmail.com

# NEW PATIENT INTAKE FORM

## PATIENT INFORMATION

LAST NAME ____________ FIRST NAME ____________ MI ____ PREFERRED NAME ____________

D.O.B ___/___/___ SSN ___-___-___ ☐ MALE ☐ FEMALE RELATIONSHIP STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

STREET ADDRESS ____________ APT NUMBER ______

CITY ____________ STATE ____________ ZIP CODE ____________

EMAIL ____________ PHONE ____________ ALT. PHONE ____________

PREFERRED METHOD OF CONTACT ☐ EMAIL ☐ TEXT ☐ PHONE CALL

IS IT OK TO LEAVE DETAILED MESSAGES ABOUT YOUR APPOINTMENTS/HEALTH CARE? ☐ YES ☐ NO

WOULD YOU LIKE TO BE ADDED TO OUR EMAIL LIST FOR NEWSLETTERS, SCHEDULE CHANGES, UPDATES, ETC.? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____________

## EMPLOYMENT INFORMATION

OCCUPATION ____________ ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT

EMPLOYER ____________ HOW LONG? ____________

## EMERGENCY CONTACT INFORMATION

WHOM SHOULD WE CONTACT? ____________ RELATION ____________

PHONE NUMBER ____________ CELL NUMBER ____________

## PATIENT PAST HEALTH HISTORY

DO YOU HAVE A HISTORY OF MAJOR TRAUMA/INJURY? (BROKEN BONES, CAR ACCIDENTS, CONCUSSIONS) ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE ____________

HAVE YOU HAD ANY SURGICAL PROCEDURES, OUTPATIENT PROCEDURES AND/OR HOSPITALIZATIONS? ☐ YES ☐ NO
IF YES, PLEASE LIST ____________

HAVE YOU HAD A PREVIOUS OR CURRENT DIAGNOSIS OF CANCER? ☐ YES ☐ NO IF YES, WHEN? ____________

## SOCIAL HISTORY

**NUMBER OF CHILDREN & AGES** ______________________ ☐ N/A I DON'T HAVE CHILDREN

**EXERCISE** ☐ DAILY ☐ 1-3 TIMES/WEEK ☐ 4-6 TIMES/WEEK **WHAT TYPES?** ______________

**ALCOHOL USE** ☐ DAILY ☐ WEEKLY ☐ MONTHLY **HOW MUCH?** ______________

**DO YOU USE RECREATIONAL DRUGS?** ☐ **YES** ☐ **NO**

**DO YOU CURRENTLY OR PREVIOUSLY USED TOBACCO PRODUCTS?** ☐ **YES** ☐ **NO**

IF SO, WHAT TYPE(S)? ______________ HOW OFTEN? ______________ HOW LONG? ______________

I QUIT USING TOBACCO PRODUCTS ON THIS DATE ___/___/___ ☐ N/A STILL UTILIZING

## FAMILY HISTORY

**USE THE FOLLOWING INDICATORS: M=** MOTHER **F=** FATHER **SI=** SISTER **B=** BROTHER **D=** DAUGHTER **SO=** SON

***M F SI B D SO*** **HEART CONDITIONS**
(HEART DISEASE, HYPERTENSION, HEART MURMURS, GENETIC DEFECTS)

***M F SI B D SO*** **INFLAMMATORY CONDITIONS**
(RHEUMATOID/PSORIATIC ARTHRITIS, GOUT, CROHN'S DISEASE/ULCERATIVE COLITIS, OTHER AUTOIMMUNE OR AUTO INFLAMMATORY CONDITIONS)

***M F SI B D SO*** **CIRCULATORY CONDITIONS**
(STROKE, HEMOPHILIA, OR OTHER)

***M F SI B D SO*** **GENETIC DISEASES (PLEASE LIST)**
______________________________

***M F SI B D SO*** **OSTEOPOROSIS OR OTHER BONE DENSITY DISEASE/CONDITION**

## CURRENT MEDICAL INFORMATION

**IN THE PAST 3 MONTHS HAVE YOU HAD OR ARE YOU EXPERIENCING:**

☐ FEVER / CHILLS / SWEATS
☐ UNEXPLAINED WEIGHT CHANGE (MORE THAN 10 LBS)
☐ DIFFICULTY SLEEPING DUE TO PAIN

**LAST PHYSICAL EXAM** ______________ **PRIMARY CARE PHYSICIAN** ______________ **CLINIC** ______________

**CURRENT MEDICATION LIST** PLEASE INDICATE DOSAGE (IF KNOWN), FREQUENCY, AND ANY OVER-THE-COUNTER MEDICATIONS, VITAMINS/SUPPLEMENTS

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

**DO YOU HAVE ANY MEDICATION ALLERGIES?** ☐ **YES** ☐ **NO** **IF SO, WHAT?** ______________

**HAVE YOU PREVIOUSLY BEEN UNDER CHIROPRACTIC CARE?** ☐ **YES** ☐ **NO** **IF SO, WHEN?**

**DO YOU TOLERATE MANUAL ADJUSTING (HANDS-ON)?** ☐ **YES** ☐ **NO** **IF NO, PLEASE EXPLAIN** ______________

______________________________
______________________________
______________________________

**ARE THERE ANY PREFERENCES YOU WOULD LIKE US TO KNOW ABOUT YOUR CHIROPRACTIC CARE?**

______________________________
______________________________

## REASON FOR TODAY'S VISIT

### PRIMARY COMPLAINT

**DESCRIBE YOUR SYMPTOMS** ____________________

**WHEN DID IT START?** ____________________

**HOW ARE YOUR SYMPTOMS CHANGING?** GETTING BETTER GETTING WORSE NOT CHANGING

**HOW OFTEN DO YOU NOTICE THESE SYMPTOMS?**

- ☐ CONSTANTLY (100% - 76%) ☐ FREQUENTLY (75% - 51%) ☐ OCCASIONALLY (50% - 26%) ☐ INTERMITTENTLY (25% - 0%)

### SECONDARY COMPLAINT

**DESCRIBE YOUR SYMPTOMS** ____________________

**WHEN DID IT START?** ____________________

**HOW ARE YOUR SYMPTOMS CHANGING?** GETTING BETTER GETTING WORSE NOT CHANGING

**HOW OFTEN DO YOU NOTICE THESE SYMPTOMS?**

- ☐ CONSTANTLY (100% - 76%) ☐ FREQUENTLY (75% - 51%) ☐ OCCASIONALLY (50% - 26%) ☐ INTERMITTENTLY (25% - 0%)

### OTHER COMPLAINT

**DESCRIBE YOUR SYMPTOMS** ____________________

**WHEN DID IT START?** ____________________

**HOW ARE YOUR SYMPTOMS CHANGING?** GETTING BETTER GETTING WORSE NOT CHANGING

**HOW OFTEN DO YOU NOTICE THESE SYMPTOMS?**

- ☐ CONSTANTLY (100% - 76%) ☐ FREQUENTLY (75% - 51%) ☐ OCCASIONALLY (50% - 26%) ☐ INTERMITTENTLY (25% - 0%)

## HISTORY OF COMPLAINT(S)

**RATE YOUR PAIN** (0= NO PAIN, 10= UNBEARABLE PAIN)

**AT ITS BEST** 0 1 2 3 4 5 6 7 8 9 10 **AT ITS WORST** 0 1 2 3 4 5 6 7 8 9 10

**WHAT MAKES YOUR SYMPTOMS BETTER?** ____________________

**WHAT MAKES YOUR SYMPTOMS WORSE?** ____________________

**ARE YOUR SYMPTOMS WORSE AT CERTAIN TIMES OF THE DAY?** ☐ **YES** ☐ **NO** **IF SO, PLEASE EXPLAIN** ____________________

**HAVE YOU BEEN SEEN BY ANYONE FOR THIS CONDITION?**

**IF SO, DATE SEEN** ___/___/___

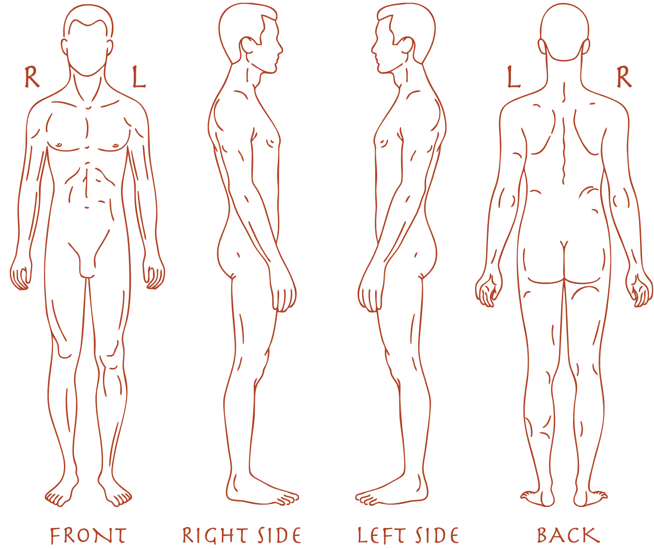
- ☐ NO ONE
- ☐ MEDICAL DOCTOR
- ☐ ER
- ☐ PHYSICAL THERAPIST
- ☐ OTHER CHIROPRACTOR
- ☐ OTHER ____________________

**HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST?** ☐ **YES** ☐ **NO** **IF SO, WHEN** ____________________

## DESCRIBE YOUR SYMPTOMS

USING THE ADJACENT BODY CHARTS, PLEASE INDICATE ALL AFFECTED AREAS AND SYMPTOMS IF YOU ARE EXPERIENCING THEM.

/ / = STABBING PAIN
B = BURNING PAIN
D = DULL PAIN
A = ACHING PAIN
SW = SWELLING
C = CRAMPS
T = TINGLING
ST = STIFFNESS
N = NUMBNESS




DO YOU HAVE ANY LOSS OF BOWEL OR BLADDER CONTROL, CHANGES IN SMELL, TASTE, HEARING, VISION, SPEECH, DIFFICULTY SWALLOWING OR WITH FACIAL EXPRESSION? ☐ YES ☐ NO IF SO, PLEASE DESCRIBE ______

## YOUR CHIROPRACTIC CARE

WHAT ARE YOU HOPING TO ACHIEVE THROUGH CHIROPRACTIC CARE? ______

______

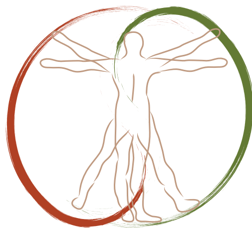
ARE THERE ACTIVITIES IN YOUR LIFE YOU ARE CURRENTLY UNABLE TO DO THAT YOU WOULD LIKE TO BE ABLE TO DO AGAIN? PLEASE EXPLAIN ______

______

______

______

BODY IN BALANCE



CHIROPRACTIC & ACUPUNCTURE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# REVIEW OF SYSTEMS

**PLEASE MARK ANY OF THE CONDITIONS BELOW THAT APPLY TO YOU, PAST OR PRESENT.**

## GENERAL HEALTH

- ☐ NONE
- ☐ FEVER
- ☐ CHILLS
- ☐ UNEXPLAINED/UNINTENTIONAL WEIGHT LOSS/GAIN
- ☐ OTHER ____________

## HEAD/EYES/EARS/NOSE/THROAT

- ☐ NONE
- ☐ HEAD INJURY
- ☐ DIZZINESS
- ☐ LIGHT-HEADEDNESS
- ☐ CHANGES IN VISION
- ☐ EYE PAIN
- ☐ REDNESS OF EYES
- ☐ EXCESSIVE TEARING
- ☐ DOUBLE OR BLURRED VISION
- ☐ SEEING SPOTS, SPECKS OR
- ☐ FLASHING LIGHTS
  SORE THROAT
- ☐ DRY MOUTH
- ☐ HOARSENESS
- ☐ OTHER ____________
- ☐ CHANGES IN HEARING
- ☐ TINNITUS
- ☐ VERTIGO
- ☐ EARACHE
- ☐ DISCHARGE
- ☐ FREQUENT COLDS
- ☐ NASAL STUFFINESS
- ☐ DISCHARGE/ITCHING OF THE NOSE
- ☐ HAY FEVER
- ☐ NOSEBLEEDS
- ☐ CHRONIC SINUS COMPLAINTS
- ☐ SWOLLEN GLANDS
- ☐ GOITER
- ☐ LUMPS OR PAIN IN NECK

## SKIN/HAIR/NAILS

- ☐ NONE
- ☐ RASHES
- ☐ LUMPS
- ☐ SORES
- ☐ BLISTERS
- ☐ GROWTHS
- ☐ ITCHING
- ☐ DRYNESS
- ☐ CHANGES IN HAIR OR NAILS
- ☐ CHANGES IN SIZE OR SHAPE OF MOLES
- ☐ OTHER ____________

## REPRODUCTIVE

### FEMALES

- ☐ NONE
- ☐ ABNORMAL DISCHARGE OR BLEEDING
- ☐ EXCESSIVE MENSTRUAL BLEEDING
- ☐ ABNORMAL FREQUENCY OR DURATION OF MENSTRUAL CYCLES
- ☐ PCOS
- ☐ LUMPS OR DISCHARGE FROM BREASTS
- ☐ INFERTILITY
- ☐ OTHER ____________

### MALES

- ☐ NONE
- ☐ HERNIAS
- ☐ DISCHARGE
- ☐ SORES
- ☐ PAINS
- ☐ MASSES
- ☐ SWELLINGS
- ☐ INFERTILITY
- ☐ ERECTILE DYSFUNCTION
- ☐ OTHER ____________

## HEMATOLOGIC/LYMPHATIC

- ☐ NONE
- ☐ ABNORMAL BLEEDING
- ☐ OTHER ____________

## HEART/CARDIOVASCULAR

- ☐ NONE
- ☐ CHEST PAIN OR PRESSURE
- ☐ ARRHYTHMIA OR PALPITATIONS
- ☐ SHORTNESS OF BREATH
- ☐ SWELLING/EDEMA
- ☐ BLOOD CLOTS
- ☐ VARICOSE VEINS
- ☐ CRAMPING IN THIGHS
- ☐ OTHER ____________

## GASTROINTESTINAL SYSTEM:

- ☐ NONE
- ☐ ABDOMINAL PAIN
- ☐ NAUSEA
- ☐ REDUCED APPETITE
- ☐ BLOODY OR BLACK TARRY STOOL
- ☐ FREQUENT URINATION
- ☐ PAIN OR BURNING DURING URINATION
- ☐ FLANK PAIN
- ☐ OTHER ____________

## ENDOCRINE

- ☐ NONE
- ☐ HEAT OR COLD RESISTANCE
- ☐ EXCESSIVE THIRST
- ☐ EXCESSIVE HUNGER
- ☐ OTHER ____________

## PSYCHIATRIC CONDITIONS

- ☐ DIAGNOSIS ____________
- ☐ NO DIAGNOSED PSYCHIATRIC CONDITIONS

## NEUROLOGIC

- ☐ NONE
- ☐ HEADACHE
- ☐ VERTIGO
- ☐ FAINTING
- ☐ BLACKOUTS
- ☐ WEAKNESS
- ☐ PARALYSIS
- ☐ TREMORS
- ☐ SEIZURES
- ☐ OTHER ____________
- ☐ NUMBNESS OR LOSS OF SENSATION
- ☐ TINGLING OR FEELING OF "PINS AND NEEDLES"
- ☐ CHANGES IN MOOD, ATTENTION OR SPEECH
- ☐ CHANGES IN ORIENTATION/MEMORY/JUDGEMENT

## RESPIRATORY

- ☐ NONE
- ☐ WHEEZING
- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ OTHER ____________

## ALLERGIC/IMMUNOLOGIC

- ☐ NONE
- ☐ IMMUNE DEFICIENCIES
- ☐ HAY FEVER
- ☐ OTHER ____________

**PATIENT SIGNATURE** ____________________ **DATE** ___/___/___