Chiropractic Intake & History

Patient Information

Patient Name:

_____
First Name Middle Initial Last Name

Address _____

City _____

State _____ Zip Code _____

Cell Phone _____

Email _____

Sex □ M □F Age_____ Birthday_____

□ Married □ Widowed □ Single □ Divorced

Employer / School_____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you?

_____
First Name Last Name

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

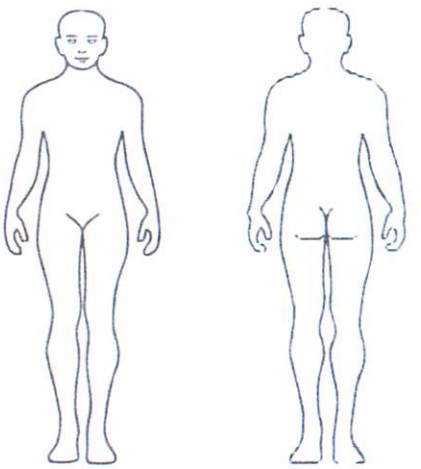
If you are already experiencing a symptom, what is it?_____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS INTENSE SYMPTOMS

Please circle the areas to the right where you have pain or other symptoms:



What does it feel like? (Check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other_____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (Check where appropriate)

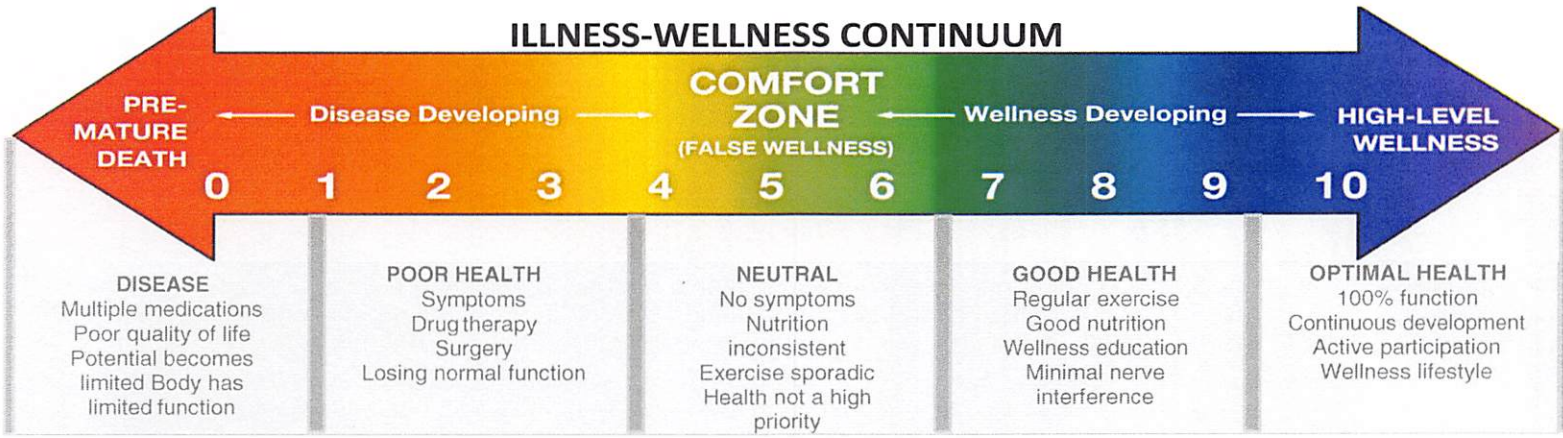
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationship	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

Not Committed — Very Committed

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

What number do you think represents your health today? _____

In what direction is your health currently headed? _____

What are your health goals?

Immediate: _____

_____

Short Term: _____

_____

Long Term: _____

_____

Children and Pregnancy

How many children do you have? _____

Are you currently pregnant? □ No □ Yes, I am due _____

Children's' ages? _____

Number of past pregnancies? _____

Children's' health concerns? _____

Health concerns regarding this pregnancy? _____

HEALTH AND ILLNESS HISTORY Please check the box beside any condition that you have or have had

- □ AIDS/HIV
- □ Alcoholism
- □ Anxiety
- □ Arteriosclerosis
- □ Arthritis
- □ Asthma/Allergies
- □ Back Pain
- □ Cardiovascular Issues
- □ Cancer
- □ Circulation Issues
- □ Childhood Illness
- □ Depression
- □ Digestive Issues (constipation/Diarrhea/GE RD/IBS
- □ Elbow/Wrist/Hand Issues
- □ Endocrine Issues
- □ Foot/Ankle Issues
- □ Gout
- □ Headaches/Migraines
- □ Heart Disease
- □ Hepatitis
- □ Hip Issues
- □ Immune Issues
- □ Lymphatic Issues
- □ Multiple Sclerosis
- □ Neck Pain
- □ Reproductive Issues
- □ Ringing in the Ears
- □ Scoliosis
- □ Shoulder Issues
- □ Stroke
- □ TMJ Issues
- □ Urinary Issues
- □ Osteoporosis
- □ Other

_____

_____

ALLERGIES, MEDICATIONS, & SUPPLEMENTS

Allergies (list)	Medications (list)	Supplements (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ **Date** _____