CHIROPRACTIC INTAKE & HISTORY

Date: _____

Who may we thank for referring you? _____

Have you been to a chiropractor before? Yes No

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age __ Birthday _____

☐ Married ☐ Widowed ☐Single ☐ Minor

☐ Separated ☐ Divorced ☐Partnered

Employer/ School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Family Physician _____

IN CASE OF EMEGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

HOW CAN WE HELP YOU?

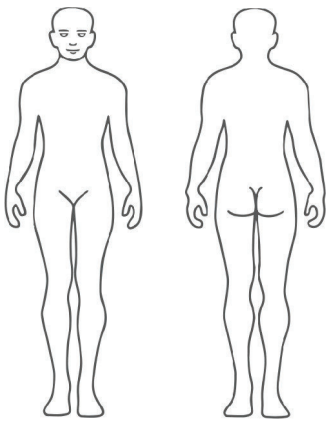
What brings you in today? _____

How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

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



What does it feel like? (check where appropriate)

D Numbness
D Tingling
D Stiffness
D Dull
D Aching
D Cramping
D Nagging
D Sharp
D Shooting
D Burning
D Throbbing
D Stabbing
D Swelling
D Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom *I* 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	☐	D	☐	D	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	D	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	D	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

Go to the next side to complete

CHILDREN & PREGNANCY

Are you currently pregnant? ☐ No ☐ Yes

How many children do you have? _____

Health concerns regarding this pregnancy?_____

Childrens' ages? _____

Social History

Tobacco Use: ☐ No ☐ Yes, Packs/Day _____

Use of Alcohol ☐ No ☐ Yes, Daily /Occasional _____

HEALTH & ILLNESS HISTORY

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERO/I BS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease Hepatitis
- ☐ Hip Issues Immune
- ☐ Issues Lymphatic
- ☐ Issues Multiple
- ☐ Sclerosis Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)