CHIPROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

DATE:

Patient Name ______________________
LAST NAME

____
FIRST NAME MIDDLE NAME

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 ______________________

Spouse's Occupation ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Contact Number ______________________

Who may we thank for referring you? ______________

HOW CAN WE HELP YOU?

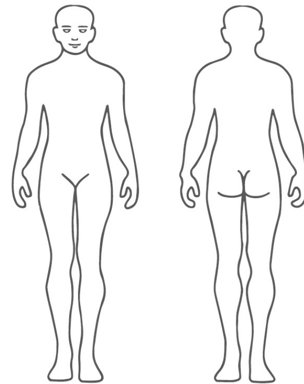
☐ Wellness Checkup Other: ______________________

____

If you are experiencing a symptom, when did it start? ______________________

How bad is it? How intense are your symptoms? (circle) **No Symptoms 1 2 3 4 5 6 7 8 9 10 Severe Symptoms**

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



What does it feel like? (check where appropriate)

☐ Numbness ☐ Tingling ☐ Sharp

☐ Shooting ☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing ☐ Stabbing

☐ Aching ☐ 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	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	________ OTHER	☐	☐	☐	☐

How committed are you to correcting this issue? (circle) **Not Committed 1 2 3 4 5 6 7 8 9 10 Very Committed**

WELLNESS ASSESSMENT

On the arrow diagram above:

A. What number do you think represents your health today? ____

B. In which direction is your health currently headed? ____

C What are your health goals? (ex. Run a 5K, consistent exercise, play with the kids/grandkids etc.)

____

WHAT ARE YOUR CHIROPRACTIC EXPECTATIONS? Circle One

IMMEDIATE - Pain Relief with approximately 5-10 visits

LONG TERM - Pain relief followed by corrective care and education to help prevent further decrease in overall health. Frequency of visits will depend upon the severity of spinal deterioration.

CHILDREN & PREGNANCY

How many children do you have? ____________________

Children's names & ages? ____________________

Children's health concerns? ____________________

Are you currently pregnant? No Yes, I am due ________

Number of past pregnancies? ____________________

Health concerns regarding this pregnancy? ____________

HEALTH & ILLNESS HISTORY

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERDS/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Gout
- ☐ Migraine
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Knee/Ankle/Foot 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)

____

____

____

____

____

TRAUMA HISTORY

Any motor vehicle accidents? Yes or No

Any work- related accidents? Yes or No

Any sports related accidents? Yes or No

Any recent slips/falls? Yes or No