CHIROPRACTIC INTAKE & HISTORY

MUTHERSBAUGH CHIROPRACTIC

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?

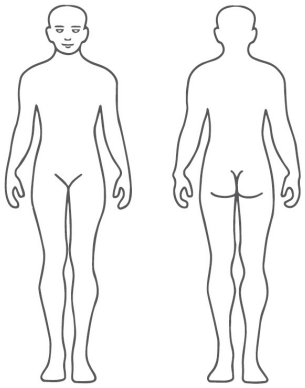
☐ Wellness Checkup Other: _____

_____

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**

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**
Previous Chiropractic Care? **Yes or No**
If Yes… When?_____

CONSULTATION & EXAM

To begin today's visit, we will be collecting confidential health information. After we learn more about your condition, we will perform some preliminary screening tests.
We will recommend a complete examination so we can thoroughly evaluate your condition. We will always inform you of associated fees before we perform any procedure or service.

REPORT OF FINDINGS

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

CARE PLAN

We will recommend care options based on your unique needs and then an individualized care plan will be created to address your health goals. As you advance through care, periodic progress evaluations will measure and compare your improvement.