Chiropractic Intake & History

Patient Information

Patient Name:______________________________

Address:__________________________________

City:____________________ State:_____ Zip:______

Home Phone:_______________________________

Cell Phone:_______________________________

Email:____________________________________

Sex ☐M ☐F Age _____ Birth Date_________

☐Married ☐Single

Employer| School _____________________________

Occupation___________________________________

Spouse's Name ________________________________

Spouse's Occupation___________________________

IN CASE OF EMERGENCY, CONTACT

Name ____

Relationship __________________________________

Contact Number _______________________________

Who may we thank for referring you? ___________________________

What Can We Do To Help?

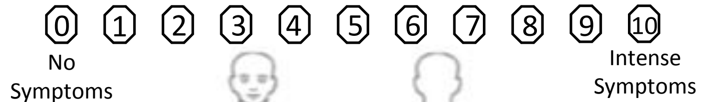
What brings you in today?____

____

If you are experiencing a symptom, what is it?_____________________________

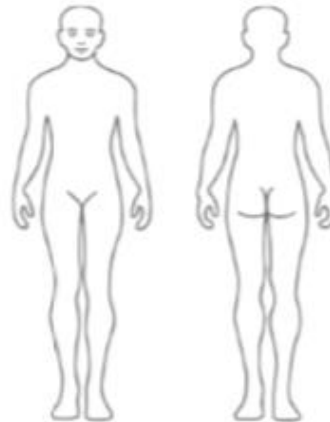
____

How Bad is it? How intense are your symptoms? (Circle)



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)

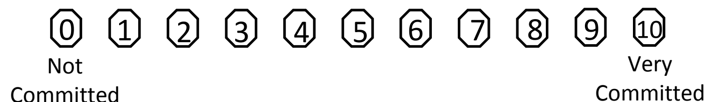
__Numbness
__Tingling
__Stiffness
__Dull
__Aching
__Cramping
__Nagging
__Sharp
__Shooting
__Burning
__Throbbing
__Stabbing
__Swelling
__Other __________________

Impact of Your Symptoms

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

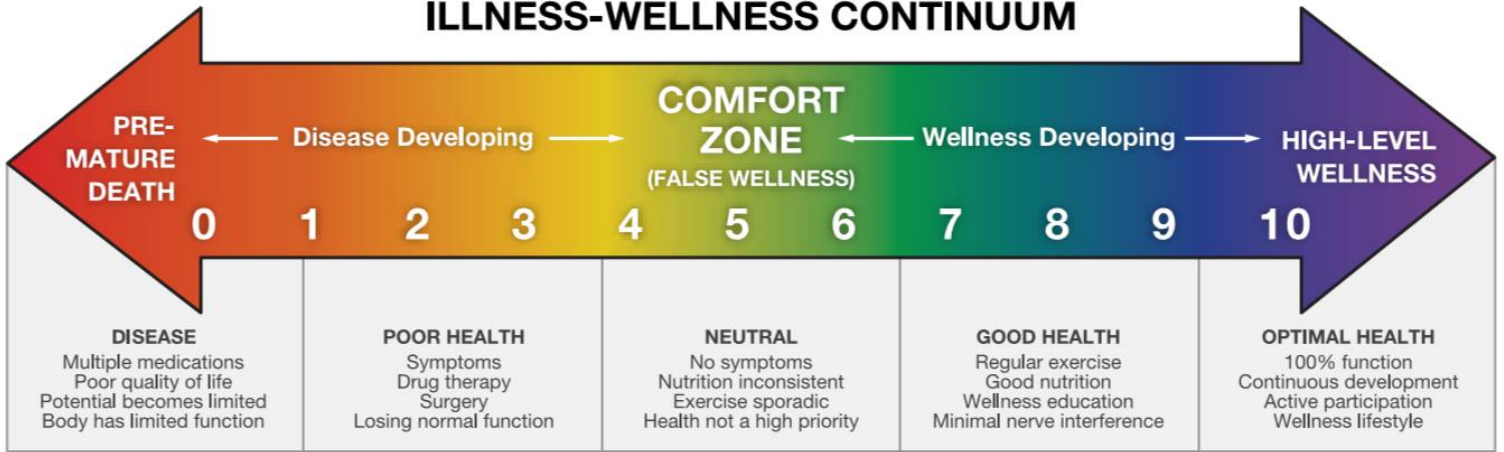
Effect	None	Mild	Moderate	Severe	Effect	None	Mild	Moderate	Severe
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_________	☐	☐	☐	☐

How committed are you to correcting this issue? (Circle)



Not Committed — Very Committed

Patient Wellness Assessment



On the arrow above:

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

B. What direction is your health currently headed?____

What are your health goals?

IMMEDIATE____

SHORT TERM____

LONG TERM____

Children & Pregnancy

How many children do you have? ________________

Children's 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

__AIDS/HIV
__Alcoholism
__Anxiety
__Arteriosclerosis
__Arthritis
__Asthma/Allergies
__Back Pain
__Cardiovascular Issues
__Cancer

__Circulation Issues
__Childhood Illness
__Depression
__Diabetes
__Digestive Issues
(Constipation/Diarrhea/GERD/IBS)
__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
__TJM Issues
__Urinary Issues
__Osteoporosis
__Other________________
____

Allergies, Medications & Supplements

Allergies (list)

____
____
____
____

Medications (list)

____
____
____
____

Supplements (list)

____
____
____
____