

# Health History Intake Form

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status (M S W D) Children \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security# \_\_\_\_\_

**Health/History Information:** Have you had previous Chiropractic Care?  Yes  No

If so, when and for what condition? \_\_\_\_\_

How was your experience? \_\_\_\_\_

Have you had previous CFR/NCR/BNS/Cranial Balloon Therapy Before?  Yes  No

If so, when, by whom, and for what condition? \_\_\_\_\_

How was your experience? \_\_\_\_\_

**Dental History:** Braces? Root canals? Extractions? Current dental issues? Dental surgeries? \_\_\_\_\_

**Are you allergic to latex?**  Yes  No **Are you absolutely positive?**  Yes  No

## Patient Questionnaire:

What is your primary complaint and rate of severity? (1 to 10 with 10 being the worst) \_\_\_\_\_

How long have you had these symptoms? Approximate onset? \_\_\_\_\_

Do you have any other complaints? \_\_\_\_\_

Have you ever had any head, facial, jaw trauma, or surgery? \_\_\_\_\_

Do you ever have difficulty breathing out of your nose? \_\_\_\_\_

Other Conditions (Please check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headache        | <input type="checkbox"/> Sinusitis                    | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Facial Pain     |
| <input type="checkbox"/> Neck stiff      | <input type="checkbox"/> Sleep Apnea                  | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Back pain       | <input type="checkbox"/> Difficulty Breathing         | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Jaw pain        | <input type="checkbox"/> Sensitivity to Light         | <input type="checkbox"/> Loss of smell   |
| <input type="checkbox"/> Jaw clicking    | <input type="checkbox"/> Numbness in Fingers          | <input type="checkbox"/> Loss of taste   |
| <input type="checkbox"/> Teeth grinding  | <input type="checkbox"/> Numbness in Toes             | <input type="checkbox"/> Chest pain      |
| <input type="checkbox"/> Teeth clenching | <input type="checkbox"/> Pins & Needles in arm/hands  | <input type="checkbox"/> Feet cold       |
| <input type="checkbox"/> Dental surgery  | <input type="checkbox"/> Pins & Needles in legs/feet  | <input type="checkbox"/> Hands cold      |
| <input type="checkbox"/> Braces          | <input type="checkbox"/> Tingling or numbness in face | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Concussions     |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Memory Loss                  | <input type="checkbox"/> Addictions      |

Do you have family members with similar symptoms? \_\_\_\_\_

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What have you done for treatment of these symptoms? Start from the beginning and include the number of doctors seen and type of drugs taken. Any surgeries? \_\_\_\_\_

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Have your symptoms changed since the onset – have they gotten better or worse? Explain: \_\_\_\_\_

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To what extent have these health problems interfered with your normal life? \_\_\_\_\_

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How did you hear about Cranial Facial Release Technique (CFR)? \_\_\_\_\_

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How are you hoping CFR will help you? What are your treatment goals? \_\_\_\_\_

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