

CHIROPRACTIC INTAKE & HISTORY



PATIENT INFORMATION

Patient Name _____
LAST NAME

Address _____
FIRST NAME MIDDLE INITIAL

City _____ Zip _____ State _____

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 _____

Who may we thank for referring you? _____

If patient is under 18, please provide parents name.

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

How bad is it? 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)

☐ Numbness

☐ Sharp

☐ Tingling

☐ Shooting

☐ Stiffness

☐ Burning

☐ Dull

☐ Throbbing

☐ Aching

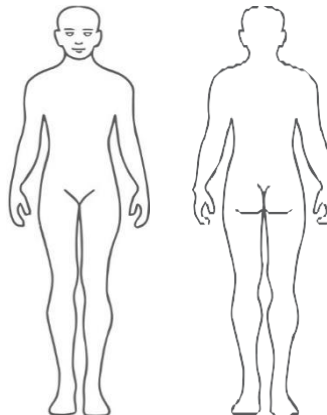
☐ Stabbing

☐ 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?

0

1

2

3

4

5

6

7

8

9

10

NOT
COMMITTED

VERY
COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

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

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____ Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Childrens' ages? _____ Number of past pregnancies? _____

Childrens' health concerns? _____ Health concerns regarding this pregnancy? _____

Difficulty getting pregnant? _____ OBGYN/Midwife: _____

Breastfeeding or Bottle? _____ Office: _____

Birth Plan: _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|---|--|---|--|
| ☐ 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
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other _____ |
|---|--|---|--|

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

Authorization: I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary.

Signed: _____ Date: _____

PREVIOUS CHIROPRACTIC EXPERIENCE

Have you been to a chiropractor before? Yes No

How often were you going and for how long? : _____

Last time you went to previous doctor of chiropractic: _____

General practitioner: _____ City: _____

MEDICAL HISTORY

Have you had the same or similar problem(s) before? ____ Yes ____ No

How long? _____ Please explain: _____

Is this the result of an auto or work injury? _____ If so, when? _____

Other doctors who have treated this problem: _____

Diagnoses or Surgeries you have had: _____

Medication(s) you currently take: _____

Have you ever been diagnosed with cancer? ____ If so, what type? _____

TRAUMA HISTORY

When was your most recent car accident? When was the last accident prior to this one?

Impacts as little as 5mph cause scar tissue to form in your spine

As a child were you athletic: what sports did you play? What are some sports or activities you are currently involved in? _____

Any major slips, trips, or falls resulting in sprains, strains, or broken bones? Have you ever fallen down the steps? (Trampoline, slips on stairs or ice, rough housing as a kid)

Your body remembers each and every impact through fibrosis or scar tissue

Pregnancy Complications/Experience/Delivery/Breastfeeding/Difficulty getting pregnant?

Momiversary Date: (First child's birth month) _____

Have you ever had headaches or back pain which caused you to miss work? Describe typical positions and activities you regularly do at work.

Sitting for long periods causes weaknesses in the spine

FOLLOW UP QUESTIONS

Headaches/Migraines? _____

Digestion Issues? Bloating/Constipation/Reflux _____

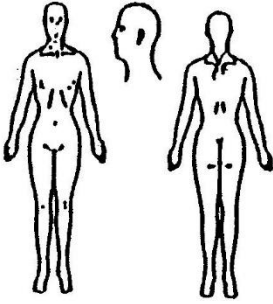
Menstrual Cycle Issues? _____

Anxiety/Stress or Depression? _____

Issues falling or staying asleep? _____

CHIEF COMPLAINT #1

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury?

What makes it better/worse?

Better:

Worse:

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing Other:

Does it travel? Yes / No If yes, where?

Any numbness/tingling (in hands or feet)?

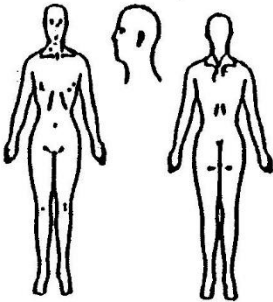
Out of 10:

/10 10 is the worst

How frequent does it occur? Daily / Constant / Intermittent AM / PM Better / Worse

CHIEF COMPLAINT #2

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury?

What makes it better/worse?

Better:

Worse:

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing

Does it travel? Yes / No If yes, where?

Any numbness/tingling (in hands or feet)?

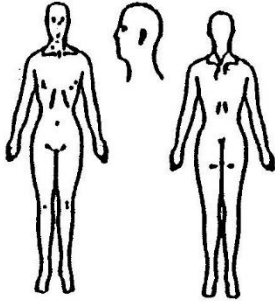
Out of 10:

/10

How frequent does it occur? Daily / Constant / Intermittent AM / PM Better / Worse

CHIEF COMPLAINT #3

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury recent or in the past?

Provokes/Palliates: What makes it better/worse?

Better: _____

Worse: _____

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing

Does it travel? Yes / No If yes, where? _____

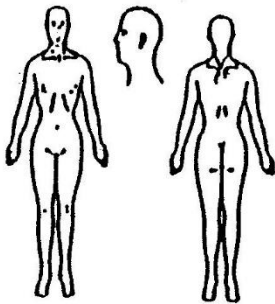
Any numbness/tingling (in hands or feet)? _____

Out of 10: ____/10

How frequent does it occur? Daily / Constant / Intermittent AM / PM Better / Worse

CHIEF COMPLAINT #4

MARK AREA(S) OF CONCERN:



When did this pain start? Was there a specific injury?

What makes it better/worse?

Better: _____

Worse: _____

What type of pain is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch Throbbing

Does it travel? Yes / No If yes, where? _____

Any numbness/tingling (in hands or feet)? _____

Out of 10: ____/10

How frequent does it occur? Daily / Constant / Intermittent AM / PM Better / Worse

YOUR GOALS FOR CARE

How do you want your life to change from chiro care? _____

What do you love to do? _____

Are there any things that you haven't been able to fully do that you'd like to get back to doing?

CHIROPRACTIC KNOWLEDGE

What have you heard about chiropractic care? _____

Do you know what a subluxation is? If yes, please describe: _____

Do you practice anything regularly for wellness? _____

PATIENT ATTESTATION

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ Date: _____