CHIROPRACTIC INTAKE & HISTORY

Today's Date:

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____

Zip _____Home Phone _____

Phone (Cell) _____

Email _____

Social Security # _____

Sex M F Age _____ Birthdate _____

Who may we thank for referring you?_____

Your Employer _____

Occupation _____

Work Phone _____

Spouse's Name _____

Spouse's Occupation _____

Name of Insurance Co _____

Prior Chiropractor _____

Last Chiropractic visit _____

Single / Married / Divorced / Widowed / Separated

HOW CAN WE HELP YOU?

Please list your health concerns according to their severity	Severity (1=mild, 10 = severe)	Date of Onset	Date of Previous Episode	Related to an Injury?	% of Time Concern is Present
1.					
2.					
3.					
4.					

IMPACT OF YOUR HEALTH CONCERNS

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 much older does this make you feel?_____ Have you become discouraged?_____

How committed are you to correcting this issue? **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

NOT COMMITTED — VERY COMMITTED

OTHER DOCTORS SEEN FOR HEALTH CONCERNS

☐ "Limited Scope" Chiropractor (focus mainly on back and neck pain)

☐ "Wellness" Chiropractor (focus on health and well-being, as well as underlying cause of pain and health concerns)

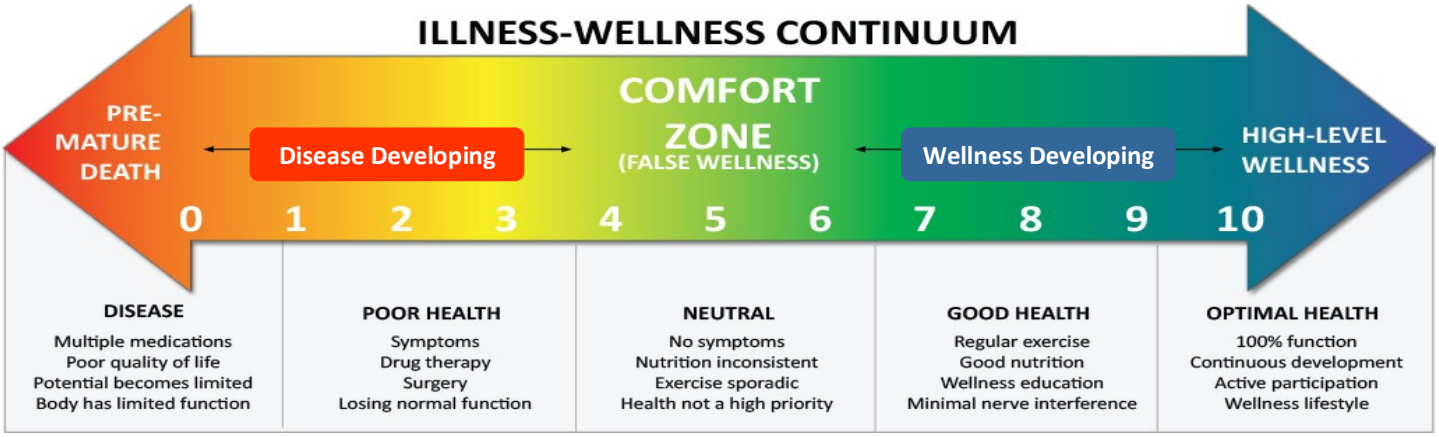
☐ Medical Doctor ☐ Naturopathic Doctor ☐ Other (please specify): _____

Are you interested in knowing more about nutrition & how it affects your overall health & well-being? Yes ☐ No ☐ Maybe ☐

If specific exercises or stretching would help, would you consider adding them to your program? Yes ☐ No ☐ Maybe ☐

If reducing stress would help, are you open to learning new ways to reduce & manage it? Yes ☐ No ☐ Maybe ☐

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_____

LONG TERM_____

CHILDREN & PREGNANCY

Are you currently pregnant? _____

Children's names and ages:

Health concerns regarding this pregnancy? _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Children's Health Concerns: _____

HEALTH & ILLNESS HISTORY

Please circle current conditions and underline past conditions

AIDS/HIV	Circulation Issues	Headaches/Migraines	Nervousness/ Irritability	Ringing/Buzzing in Ear
Alcoholism	Childhood Illness	Heart Disease	Ringing in the Ears	Shoulder Tension
Anxiety	Depression	Hepatitis	Scoliosis	Tired/Fatigued
Arteriosclerosis	Diabetes	Hip Issues	Shoulder Issues	TMJ problems
Arthritis	Digestive/ constipation	Immune Issues	Sleeping Difficulties	Urinary Issues
Asthma/Allergies	Elbow/Wrist/Hand Issues	Low Back Pain	Stroke	Weight Trouble
Back Pain	Endocrine Issues (thyroid)	Menstrual Problems	Dizziness	Fibromyalgia/Muscle Spasm
Cardiovascular Issues	Foot/Ankle Issues	Multiple Sclerosis	High Blood Pressure	Frequent colds/infections
Cancer	IBS/ Diarrhea/ GERD	Neck Pain	Osteoporosis	Other _____

ALLERGIES	MEDICATIONS	SUPPLEMENTS	SURGERIES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ABOUT YOU

Favorite Hobbies/Interests_____

Do you know what subluxation is? Please explain _____

What do you do to "Center Yourself"?_____ What do you do for daily spinal health?_____