CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____

_____

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Emain _____

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?

What brings you in today?

_____

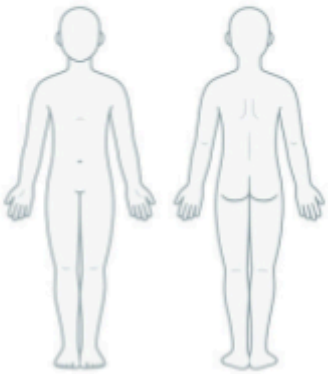
How long have you had this?

_____

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
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

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

PATIENT WELLNESS ASSESSMENT

1. How many hours of sleep do you get each night? _____ Do you feel rested? _____
2. How many hours do you work each week? _____
3. How many ounces of water do you drink each day? _____
4. Do you rely on caffeine/energy drinks to get through the day? ☐Yes ☐No
5. Do you smoke? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐No
6. How many times per week do you eat fast food or processed foods? _____
7. Do you fall frequently or lose your balance? ☐Yes ☐No
8. Do you avoid certain movements? ☐Yes ☐No If yes, which movements?

   _____
9. Rate your stress (circle): 0 (No stress) 1 2 3 4 5 6 7 8 9 10 (Severe stress)
10. What is your health goal? _____

HEALTH & ILLNESS HISTORY

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Ateriosclerosis
- ❑ 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)
_____	_____	_____
_____	_____	_____
_____	_____	_____