INTAKE

IRON SPINE CHIROPRACTIC

Name: _____ Date of Birth: _____

Occupation: _____

Is this a Worker's Compensation Case? ☐ No ☐ Yes- Date of Accident? _____

Is this a Motor Vehicle Accident Case? ☐ No ☐ Yes- Date of Accident? _____

Have you received Chiropractic care in the past? ☐ No ☐ Yes- Date of Last Visit? _____

Reason for consulting our office today:

☐ Health and spinal check-up ☐ Correct and/or prevent an existing problem – please fill out the information below

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Describe your symptoms and/or main problem: _____

_____

How and when did this problem start? _____

_____

How often are your symptoms present?

☐ Constant (75-100% of the time) ☐ Frequently (50-75% of the time)

☐ Occasionally (<50 of the time) ☐ Intermittently (comes and goes)

Since the problem started, it is: ☐ Getting better ☐ Getting worse OR about the same

Circle the number below which best describes the intensity of your pain. If it varies, circle the numbers that describe the symptoms at their best and worst:

1 2 3 4 5 6 7 8 9 10

mild moderate severe worst pain

Please check the words that describe your pain/symptoms:

☐ Sharp ☐ Dull/Aching ☐ Throbbing ☐ Radiating, to: _____

☐ Numb ☐ Tingling ☐ Burning ☐ Shooting, to: _____

Does the problem interfere with sleep, work, routine or other? _____

What aggravates your problem/symptoms? _____

What relieves your problem/symptoms? _____

Please describe any treatments and/or tests done for this problem: _____

Have you had x-rays taken of the area? ☐No ☐Yes, When? _____

Do you have any other problems or complaints? Briefly describe: _____

_____

HEALTH HISTORY

To give the Doctor a complete picture of your overall health, please check off ANY of the following symptoms you currently have or have had in the past 6 MONTHS, even if you don't think they are related to the current problem.

☐ Headaches	☐ Neck pain	☐ Diarrhea/constipation	☐ Low back/hip pain
☐ Leg/knee/foot pain	☐ Upper back pain	☐ Arm/shoulder/wrist pain	☐ Migraines
☐ Dizziness	☐ Chest pain	☐ Buzzing/ringing in ears	☐ Osteoporosis
☐ Allergies	☐ Sinus problems	☐ General fatigue	☐ Frequent colds
☐ Frequent nausea	☐ Cold feet/hands	☐ Heartburn/indigestion	☐ Sexual dysfunction
☐ Anxiousness	☐ Miscarriage(s) _____	☐ Menstrual pain/PMS	☐ Breast pain
☐ Arthritis	☐ Sleep problems	☐ Thyroid problems	☐ Asthma
☐ IBS/Colitis	☐ Painful urination	☐ High cholesterol	☐ Numbness/tingling
☐ Jaw pain	☐ Liver/gallbladder disease	☐ Depression	☐ Cancer _____

List all medications and supplements you are taking (including birth control pills): _____

_____

List any surgeries/hospitalizations and include when: _____

_____

List any car accidents and/or major falls/injuries and include when: _____

_____

Do you have a family history of: ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Diabetes

Do you personally suffer from any of the above? ☐ No ☐ Yes, _____

Is there anything else you would like us to know? _____

_____

ABOUT YOUR CARE

Chiropractic provides three types of care:

1. Initial Intensive Care: corrects the most recent layers of damage/injury and usually reduces or eliminates the symptoms
2. Reconstructive Care: also known as spinal rehabilitation, which corrects the years of damage that occurred when there were few symptoms
3. Maintenance Care: helps keep you healthy. The Doctor will explain these options to you and help you choose the care that's right for you

What do you hope to get from today's visit? Check all that apply.

☐ Explanation of condition	☐ Ability to resume/increase activity	☐ Reduce symptoms
☐ Learn what I can do to help	☐ Prevent recurrence	☐ Other: _____