20 N Fisher Park Way • Eagle, ID 83616
Ph: 208.297.1414 • F: 208.297.1413
www.LEGACYCHIRO.life

PATIENT INTAKE FORM

Date:_____/_____/_

PATIENT INTAKE OVERVIEW

First Name:_______________________________Last Name:________________________Age:________

Address:____________________________City:___________________State: Zip code: __________

Home Phone:__________________Cell Phone:__________________Work Phone: ________________

Email:_______________________________________D.O.B. :_______________ ☐ Male ☐ Female

SS#:__________________Employer:_____________________Occupation:______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Significant Other's Occupation:__________________Number of Children:_______Ages of Children: ________

How did you hear about our office? ____

PURPOSE AND GOALS

What is your reason for seeking care? ____

When did this begin (if applicable)? ____

Are there any major surgeries and/or injuries we should know about? ________________________

____

What is this affecting that is MOST important in your life? _________________________________

Have you seen any other providers for this condition? ____________________________________

Have you seen a chiropractor before? ☐ Yes ☐ No

If yes, how long ago?__________Clinic/Doctor's Name: ____________________________________

What is your reason for the change (if applicable)? _______________________________________

What is your level of commitment to yourself and your health (1 = Low, 10 = High)? 1 2 3 4 5 6 7 8 9 10

Please explain: ____

What health goal, if accomplished, would have the greatest impact on your life? ______________

____

LEGACY CHIROPRACTIC

20 N Fisher Park Way, Ste 100 • Eagle, ID 83616 • Ph: 208.297.1414 • F: 425.297.1413 • www.LEGACYCHIRO.life

HEALTH CONCERNS

- [ ] Headaches
- [ ] Dizziness
- [ ] Diabetes
- [ ] Arthritis
- [ ] Neck/Back
- [ ] Pain
- [ ] Irritability
- [ ] Light Sensitivity
- [ ] Anxiety/Depression
- [ ] Digestive Troubles
- [ ] Fatigue/Sleep Issues
- [ ] Loss of Balance
- [ ] Pain in Arms/Legs
- [ ] Ringing in Ears
- [ ] Inability to
- [ ] ConcentrateStiffness
- [ ] Other: ______________________________

Explain any boxes checked above or add additionalconcerns: ____________________________

____

____

Is there anything else regarding your current condition the Doctor should know? ____________

____

MEDICATIONS

- [ ] Anxiety/
- [ ] DepressionBlood
- [ ] Pressure
- [ ]
- [ ] Migraine/
- [ ] Headache
- [ ] Cholesterol ADD/
- [ ]
- [ ] Other: ______________________________________

Explain any checked boxes above: ___________

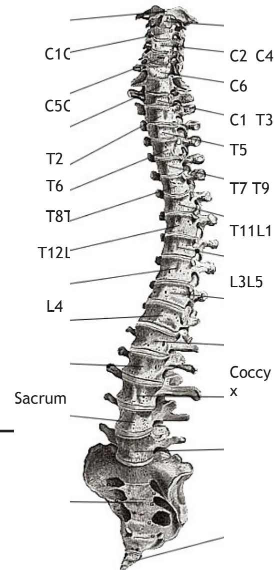
____

____

DID YOU KNOW...

Each health concern relates to a specific area of thespine and nervous system? Please circle concernsbelow or enter the information to the left.

Headache
sMigraines
Dizziness
Sinus
Problems
Allergies
Fatigue/Sleep
ProblemsHead Colds
Vision Problems
Heart Conditions
High Blood Pressure
Difficulty Concentrating



Middle Back Pain
Congestion
Difficulty
Breathing
Bronchitis
Pneumonia
Gallbladder
ConditionsStomach
Problems Ulcers
Gastritis
Kidney
Problems
Indigestion

Constipatio
nColitis
Diarrhea
Gas Pain
Irritable
Bowel
Bladder Problems
Menstrual Problems
Low Back Pain Pain/
Numbness in Legs
Reproductive
Problems

VITAMINS/SUPPLEMENTS

- [ ] Multi-
- [ ] vitamin
- [ ] Fish Oil/
- [ ] Omega-3
- [ ] Other: ______________________________

____

____

____

____

LEGACY CHIROPRACTIC

20 N Fisher Park Way, Ste 100 • Eagle, ID 83616 • Ph: 208.297.1414 • F: 425.297.1413 • www.LEGACYCHIRO.life

Additional Notes: ____

Your Physical Life	Nev	Rar	Occ	Reg	Con	**Stress Evaluation**	Nev	Rar	Oc c	Reg	Con
Presence of physical pain	1	2	3	4	5	Family	1	2	3	4	5
Colds or flu	1	2	3	4	5	Significant life change	1	2	3	4	5
Chronic disease	1	2	3	4	5	Health	1	2	3	4	5
Ability to work out or engage in activity	1	2	3	4	5	Work/school	1	2	3	4	5
Tension, stiffness, lack of flexibility	1	2	3	4	5	Day-to-day stress	1	2	3	4	5
Fatigue or low energy	1	2	3	4	5	Finances	1	2	3	4	5
Mental/Emotional State	Nev	Rar	Occ	Reg	Con	**Life Enjoyment**	Nev	Rar	Oc c	Reg	Con
Negative feelings	1	2	3	4	5	Recreational activities	1	2	3	4	5
Sleeping difficulties	1	2	3	4	5	Time devoted to hobbies	1	2	3	4	5
Depression/Anxiety	1	2	3	4	5	Experiences of well-being and relaxation	1	2	3	4	5
Moodiness, temper, angry outbursts	1	2	3	4	5	Interest in maintaining a healthy lifestyle	1	2	3	4	5
Being overly worried about small things	1	2	3	4	5						
Difficulty thinking or concentrating	1	2	3	4	5						

I agree that I have answered all questions on this form to the best of my knowledge and allow Dr. Brent Symes to

FAMILY HEALTH PROFILE

In addition to your health, we here at Legacy Chiropractic are also interested in the health and wellbeing of your loved ones. Please list any of their current health concerns below (i.e., high cholesterol, sports injuries, lack of mobility, financialstress, etc.):

Spouse/Partner:____

Parents:____

Siblings:____

Close Friends: ____

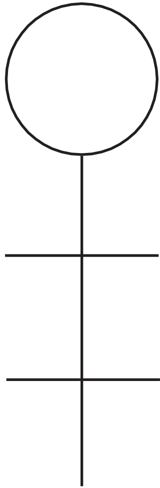
examineand help me achieve optimal health.

____________________________________ ____________________

Signature Date

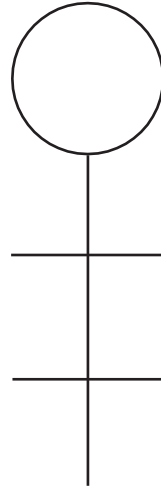
LEGACY CHIROPRACTIC

20 N Fisher Park Way, Ste 100 • Eagle, ID 83616 • Ph: 208.297.1414 • F: 425.297.1413 • www.LEGACYCHIRO.life



P - A POSTURE

Notes: ____________________



LATERAL POSTURE

Notes: ____________________

PALPATION

Cervical: 1 2 3 4 5 6 7 Thoracic: 1 2 3 4 5 6 7 8 9 10 11 12 Lumbar: 1 2 3 4 5

Notes: ____________________

RANGE OF

Cervical:	Flexation ___	Extension ___	Rotation	R ___	L ___	Lat Flexion	R ___	L ___
Thoracic:	Flexation ___	Extension ___	Rotation	R ___	L ___	Lat Flexion	R ___	L ___
Lumbar:	Flexation ___	Extension ___	Rotation	R ___	L ___	Lat Flexion	R ___	L ___

Notes: ____________________

20 N Fisher Park Way, Ste 100 • Eagle, ID 83616 • Ph: 208.297.1414 • F: 425.297.1413 • www.LEGACYCHIRO.life

Notes: ______________________________