SUMMIT
CHIROPRACTIC & WELLNESS

Chiropractic Intake and History

Patient Information

Patient Name: _____
Last First
Address: _____
City: _____ State: _____
Home Phone: _____ Cell: _____
Email: _____

Sex: M F Age: _____ Birthdate: _____
Circle One: Married Widowed Single
Minor Separated Divorced Partnered

Employer/School: _____
Occupation: _____
Spouse's Name: _____
Spouse's Occupation: _____
EMERGENCY CONTACT
Name: _____
Relationship: _____
Contact Number: _____
How Did You Hear About Us? _____
_____

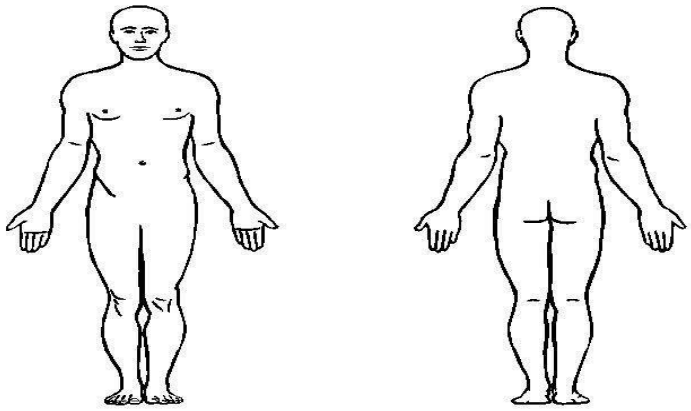
How Can We Help You?

Reason for visit? _____
What are your symptoms? _____
Is this condition getting progressively worse? _____
Rate the Severity of your pain. (Circle, 0 = no pain, 10 = worst) **0 1 2 3 4 5 6 7 8 9 10**

What does it feel like? (Check all that apply)

O **Sharp**	O **Numbness**	O **Aching**	O **Stabbing**	O **Other** _____
O **Dull**	O **Tingling**	O **Burning**	O **Shooting**	
O **Throbbing**	O **Stiffness**	O **Cramping**	O **Swelling**	

Mark with an "X" on the images where you have pain/symptoms:



Impact Of Your Symptoms

How does this condition interfere with your life? (Check all that apply)

O **Work**	O **Exercise**	O **Recreation**	O **Relationships**	O **Sleep**
O **Self-Care**	O **Energy**	O **Attitude**	O **Productivity**	O **Other** _____

Patient Wellness Assessment

On the diagram above:

What number represents your current health today? _____
In what direction is your health currently heading? _____

What are your health goals?
SHORT TERM _____
LONG TERM _____

Health and Illness History

Please check all conditions that you have currently or in the past:

O **AIDS/HIV**
O **Alcoholism**
O **Anxiety**
O **Arteriosclerosis**
O **Arthritis**
O **Asthma/Allergies**
O **Back Pain**
O **Cardiac Issues**
O **Circulation Issues**
O **Depression**
O **Diabetes**
O **Digestive Issues**
O **Elbow/Wrist/Hand Issues**
O **Endocrine Issues (Thyroid)**
O **Foot/Ankle Issues**
O **Gout**
O **Heart Disease**
O **Hepatitis**
O **Hip Issues**
O **Immune Issues**
O **Lymphatic Issues**
O **Multiple Sclerosis**
O **Neck Pain**
O **Reproductive Issues**
O **Scoliosis**
O **Shoulder Issues**
O **Stroke**
O **TMJ (Jaw) Issues**
O **Urinary Issues**
O **Osteoporosis**
O **Other** _____

List all surgeries: _____
Have you had previous traumas, injuries, or accidents? _____, please explain _____

Children and Pregnancy

How many children do you have? _____ Children's ages? _____
Children's health concerns? _____ Are you currently pregnant? _____
If currently pregnant, how many weeks? _____ How many past pregnancies? _____
Any concerns regarding this pregnancy? _____

Medications and Supplements (Please list all)

Medications: _____
_____
Supplements: _____
_____