SIMPSON
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? _____
_____

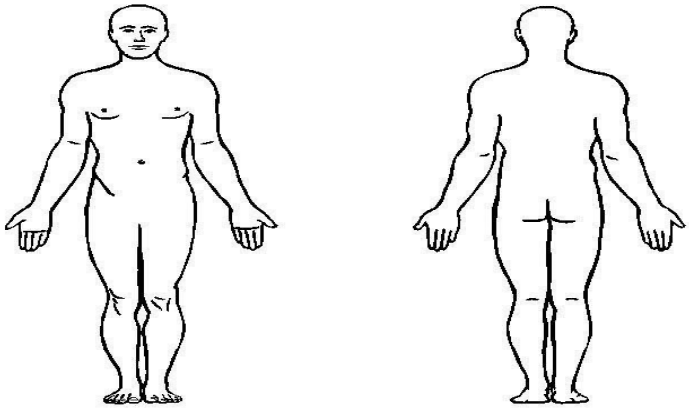
How Can We Help You?

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)

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

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

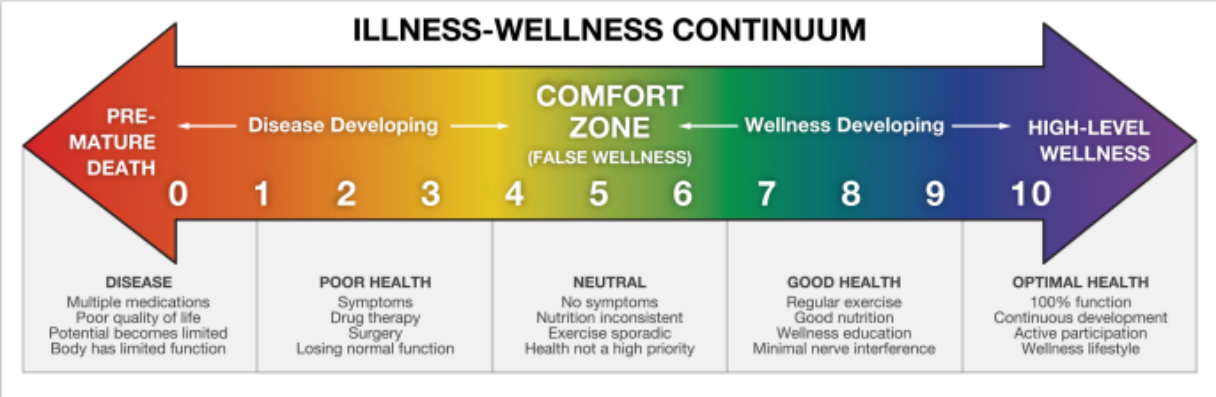


Impact Of Your Symptoms

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

☐**Work**	☐**Exercise**	☐**Recreation**	☐**Relationships**	☐**Sleep**
☐**Self-Care**	☐**Energy**	☐**Attitude**	☐**Productivity**	☐**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:

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

List all surgeries: _____
Have you had antibiotics? _____, if so, how long ago? _____

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: _____
_____