

# CHIROPRACTIC INTAKE & HISTORY

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
LAST NAME

Address \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL

City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered

Social Security # \_\_\_\_\_

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? \_\_\_\_\_

If you are already experiencing a symptom, what is it? \_\_\_\_\_

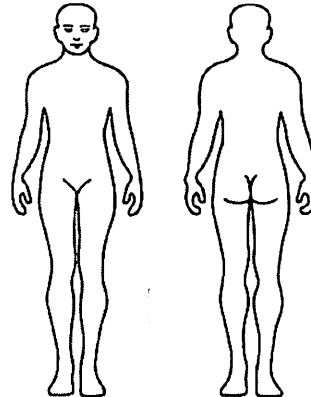
How bad is it? How intense are your symptoms? (circle)

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)

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Sharp       |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Shooting    |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning     |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Throbbing   |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Stabbing    |
| <input type="checkbox"/> Cramping  | <input type="checkbox"/> Swelling    |
| <input type="checkbox"/> Nagging   | <input type="checkbox"/> Other _____ |



## IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

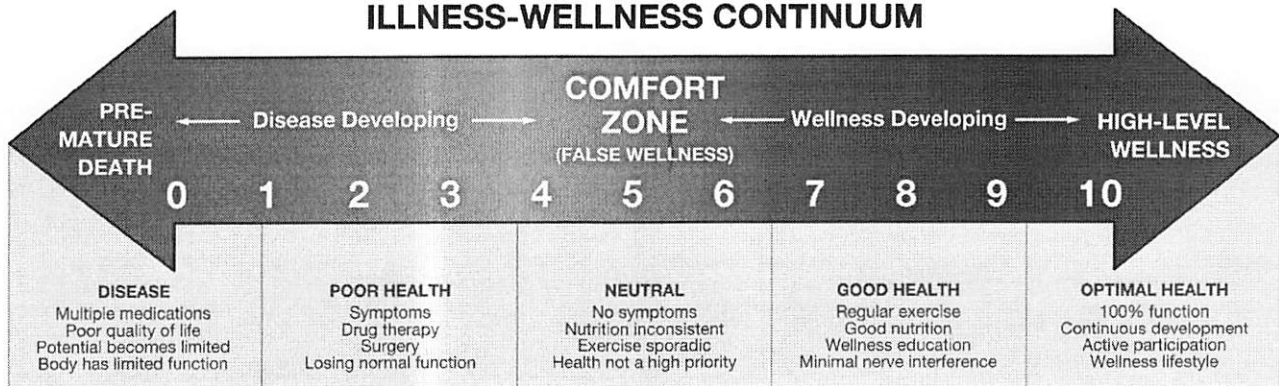
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0  1  2  3  4  5  6  7  8  9  10  
NOT COMMITTED VERY COMMITTED

## PATIENT WELLNESS ASSESSMENT

### ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? \_\_\_\_\_

B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONG TERM \_\_\_\_\_

## CHILDREN & PREGNANCY

How many children do you have? \_\_\_\_\_

Childrens' ages? \_\_\_\_\_

Childrens' health concerns? \_\_\_\_\_

Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Number of past pregnancies? \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues                                   | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness                                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Scoliosis       |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hip Issues            | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Digestive Issues<br>(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues         | <input type="checkbox"/> TMJ Issues      |
| <input type="checkbox"/> Asthma/Allergies      | <input type="checkbox"/> Elbow/Wrist/Hand Issues                              | <input type="checkbox"/> Lymphatic Issues      | <input type="checkbox"/> Urinary Issues  |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Endocrine Issues (Thyroid)                           | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues                                    | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Gout   | <input type="checkbox"/> Reproductive Issues   | _____                                    |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENTS (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\$0    \$25    \$47    \$75    \$285    \$ \_\_\_\_\_

Reactivation (\$47)   Last Visit: \_\_\_\_\_

# CONSULTATION NOTES

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Hx Trauma

MVA's: \_\_\_\_\_

Work: \_\_\_\_\_

Sports: \_\_\_\_\_

Children/Pregnancy: \_\_\_\_\_

Misc.: \_\_\_\_\_

## Chief Complaint

Onset: \_\_\_\_\_

Provoc: \_\_\_\_\_

Palative: \_\_\_\_\_

Quality: \_\_\_\_\_

Time: \_\_\_\_\_

Stress: \_\_\_\_\_

Referred: \_\_\_\_\_

Associated: \_\_\_\_\_

## Notes on Life Effect

Work \_\_\_\_\_  Sleep \_\_\_\_\_  Patience \_\_\_\_\_

Exercise \_\_\_\_\_  Self-Care \_\_\_\_\_  Productivity \_\_\_\_\_

Recreation \_\_\_\_\_  Energy \_\_\_\_\_  Creativity \_\_\_\_\_

Relationships \_\_\_\_\_  Attitude \_\_\_\_\_  Other \_\_\_\_\_

## Health Goals

Immediate: \_\_\_\_\_

Short Term: \_\_\_\_\_

Long Term: \_\_\_\_\_

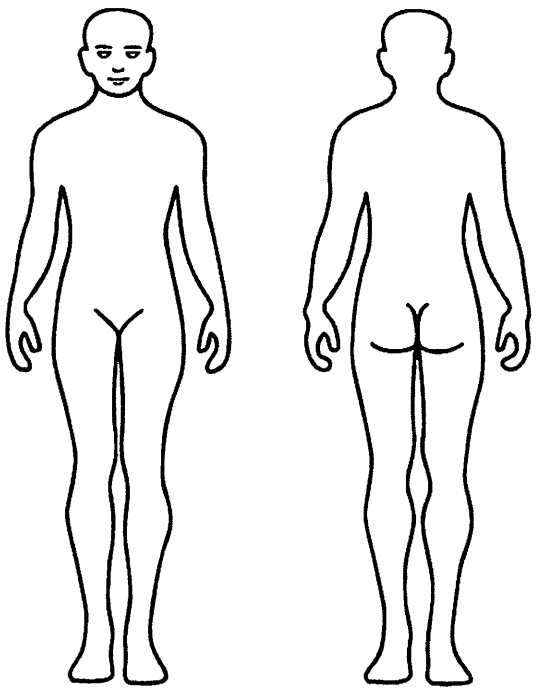
# CONSULTATION NOTES

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

	Δ T	EDEMA	T/P	Restrictions
OCCIPUT L/R				
CERVICAL - 1 L/R				
C2				
C3				
C4				
C5				
C6				
C7				
THORACIC - 1				
T2				
T3				
T4				
T5				
T6				
T7				
T8				
T9				
T10				
T11				
T12				
LUMBAR - 1				
L2				
L3				
L4				
L5				
SI JOINT L/R				
SACRUM 1				
S2				
S3				
S4 / S5				
COCCYX (1-4)				

**Visualization, Instrumentation,  
Static Palpation, Motion Palpation**



**Biostructural Exam**

Bilateral Weight Scales: Left \_\_\_\_\_ Right \_\_\_\_\_

**Exam Requisition**

LAT Full Spine                       Thermal Scan  
 AP Full Spine                         Extremity \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Requesting Doctor: \_\_\_\_\_

**Additional Notes**

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