CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Today's Date _____

(Please Print)

Full Name: _____

Address: _____

_____

_____

Home Telephone: _____

Mobile Number: _____

E-mail: _____

Date of Birth: _____ Age: _____

Occupation: _____ Work Telephone: _____

Brief Job Description (if req'd): _____

Marital Status: **M S W D** Spouse's Name: _____

Spouse's Occupation: _____

Number & Age Of Children: _____

_____

GP's Name & Address: _____

Who may we thank, for referring you to our office? _____

Have you ever been to a chiropractor before? _____

When was your last adjustment: _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

What happened?_____

And when? _____

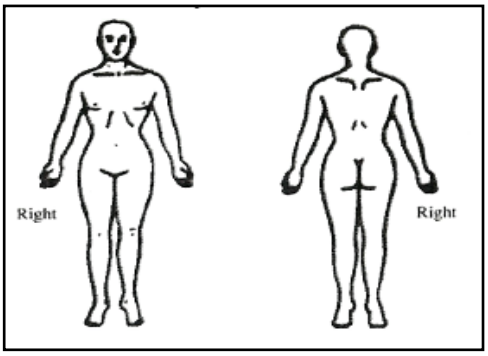
Why come here now? _____

How bad is it? 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Is it getting worse? _____

Please mark areas of pain or other symptoms on the illustration below:



What does it feel like? (tick where appropriate): □ Numbness □ Sharp □ Dull □ Aching

□ Cramping □ Nagging □ Shooting □ Burning □ Throbbing □ Stabbing

□ Other _____

IMPACT OF YOUR SYMPTOMS

How is this problem interfering with your life (tick where appropriate):

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Work	□	□	□	□
Exercise	□	□	□	□
Hobbies	□	□	□	□
Relationships	□	□	□	□
Sleep	□	□	□	□
Energy	□	□	□	□
Mood	□	□	□	□
Other _____	□	□	□	□

EXPECTATIONS

What are you hoping we can do for you (tick which apply)? Help you to:

1) Simply Get Some Temporary Pain Relief _____

2) Identify & Correct The Cause of Your Problem/Health Issue _____

or 3) Try And Achieve Optimal Health So Your Body Can Function As Well As Possible _____

If you didn't have this problem what ONE thing would you want to do? (i.e. what is it stopping you from doing?) _____

_____

If this problem got worse, what would be your greatest fear? _____

_____

How committed are you to correcting this issue (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not Committed — Very Committed

CURRENT STATE OF HEALTH

On the diagram above:

1) What number do you think represents your health today? _____

2) In what direction is your health currently headed (to the left or right)? _____

What are your health goals?

Now _____

In the Future _____

Or is your health just not that important at this stage _____

HEALTH & ILLNESS HISTORY

Check the following conditions you may have had or do have now:

□ AIDS/HIV □ Alcoholism □ Arteriosclerosis □Arthritis □Asthma/Allergies □ Anxiety

□ Cancer □ Cardiovascular issues □ Circulation issues □ Depression □ Diabetes

□ Digestive issues (constipation, IBS) □ Epilepsy □ Gall Bladder □ Gout

□ Headaches/Migraines/Sinus □ Heart Disease □ Hepatitis □ High Blood Pressure

□ Immune Issues □ Irregular Periods □ Menstrual Cramps □ Miscarriage □ MS

□ Neck Pain □ Osteoporosis □ Pneumonia □ Reproductive issues □ Stroke

□ Ringing in Ears □ Thyroid □ Urinary issues □ Other _____

Have you had any accidents & when? _____

Or Falls? _____

Have you had any surgery? _____

Any relevant family history? _____

_____

"MEDICAL" CONDITIONS

MEDICATION	WHAT IS IT SUPPOSED TO DO?	HOW LONG HAVE YOU BEEN TAKING IT?

CONSENT

I understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____**Date:** _____

Guardian's Signature (where appropriate)_____**Date:** _____

Information taken by_____**Date:** _____