# CHIROPRACTIC INTAKE & HISTORY

## PATIENT INFORMATION

Today's Date _____

**(Please Print)**

Full Name: _____

Address: _____

_____

_____

Home Telephone: _____

Mobile Number: _____

E-mail: _____

Age: _____Date of Birth: _____

Occupation: _____ Work Telephone: _____

Brief Job Description: _____

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?** _____

## HOW CAN WE HELP YOU?

What brings you in today? _____

_____

What happened?_____

And when? _____

## 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 | ☐ | ☐ | ☐ | ☐ |
| Family | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Energy | ☐ | ☐ | ☐ | ☐ |
| Mood | ☐ | ☐ | ☐ | ☐ |

## EXPECTATIONS

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

1) Simply Get Some Temporary Pain Relief _____ or

2) Correct The Cause of Your Problem/Health Issue & Aim For Optimal Health So Your Body Can Function As Well As Possible _____

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

## PREVIOUS CARE

What other treatments/specialists/therapists have you seen/tried for your condition?

_____

_____

How successful were they? _____

Why come here now? _____

Ever been to a chiropractor before? _____ When was that? _____

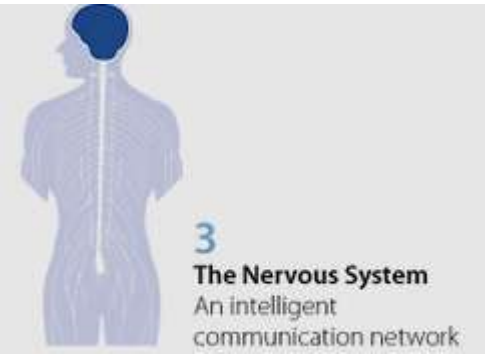
## HEALTH & ILLNESS HISTORY

There are 6 kinds of disturbances that can affect the human body: GLANDULAR, ELIMINATIVE, NERVOUS, DIGESTIVE, MUSCULAR & CIRCULATORY. All dis-ease conditions, aches and pains and other discomforts can be attributed to one or more disturbances to the body's 6 systems or "ZONES".

**Please check all issues or problems that apply below:**


□ memory loss □ adrenals □ sleep □ skin
□ anxiety/depression □ ED/fertility □ thyroid
□ hair □ hot tempered □ menstrual issues
□ low energy □ disturbed appetite
□ low immunity □ inability to concentrate

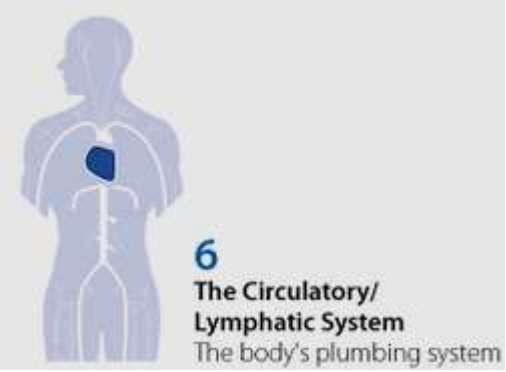

□ sinuses □ nasal passages □ throat □ lungs
□ kidneys □ bronchitis / pneumonia □ bladder
□ lymphatic drainage □ bloating / toxins
□ intestines / colon




□ eyes □ ears □ balance / dizziness
□ tension □ tingling in arms or legs
□ poor sleep □ allergies / food sensitivities
□ digestion □ unable to relax □ nervousness
□ hormone imbalances


□ poor appetite □ taste □ acid reflux □ liver
□ heart burn □ gall bladder □ stomach
□ pancreas □ intestines □ weight gain
□ digestion □ elimination


□ lack of mobility □ neck pain □ shoulder pain
□ arms / hand discomfort □ chest pain
□ abdominal pain □ upper back pain
□ mid back pain □ low back pain □ weakness
□ disc problems □ muscular / joint pain




□ thyroid □ blood pressure issues
□ heart problems □ headaches / migraines
□ cold hands □ cold feet □ poor circulation

Are you currently under a lot of stress?_____

Do you have difficulty concentrating? _____

Do you get "sick" more than twice a year? ☐ Yes ☐ No

Are you sick of being "sick & tired" ☐ Yes ☐ No

## TRAUMA HISTORY

Have you had any accidents? _____

_____

When? _____

What happened? _____

_____

Any other falls or Surgery?

_____

## "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:** _____