CHIROPRACTIC INTAKE & HISTORY FORM

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?

_____

_____

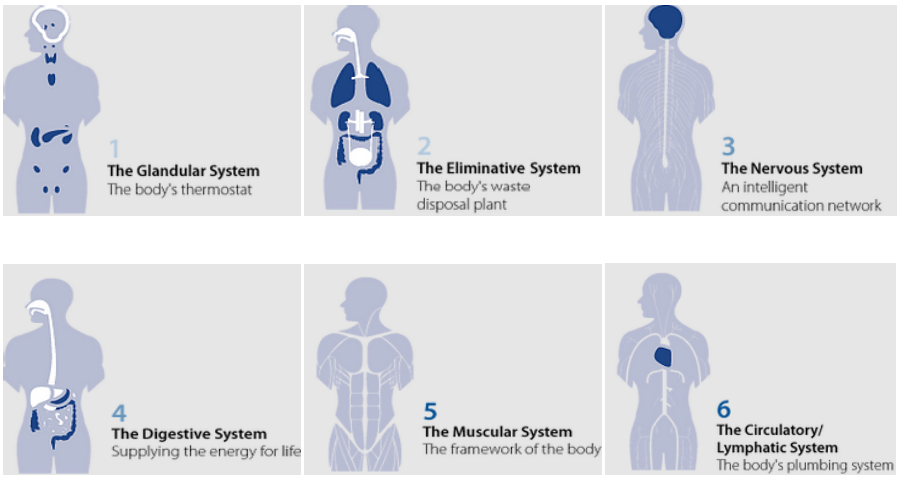
How successful were they? _____

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 indicate whether you have any problems or issues with any of the following please check all that apply:

☐ memory ☐ sleep ☐ appetite ☐ anxiety/depression ☐ concentration ☐ energy ☐ hormonal / menstrual issues ☐ breathing issues ☐ bloating ☐ kidney problems ☐ bladder control or frequency problems ☐ sinus ☐ difficulty sleeping ☐ digestion ☐ congestion ☐ eye and ear health ☐ acid reflux or heartburn ☐ difficulty relaxing ☐ thyroid ☐ allergies / food sensitivities ☐ decreased range of motion / mobility ☐ dizziness / balance issues ☐ cold hands or feet ☐ blood pressure issues

Are you currently under a lot of stress?_____

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:** _____