CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name ____
LAST NAME

____
FIRST NAME MIDDLE INITIAL

Address ____

City________________________________ State ___________

Home Phone ____

Cell Phone ____

Email ____

Sex ☐ M ☐ F Age _____ Birthday _________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

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?

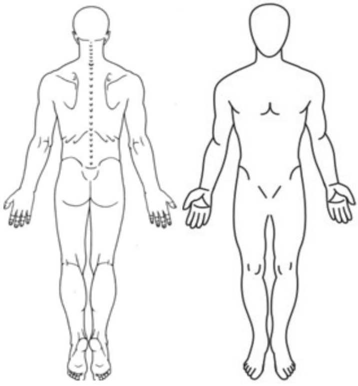
What brings you in today? ____

____

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)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ 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
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other ______________	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

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

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ (Constipation/Diarrhea/HERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other ______________________
- ☐ ____________________________

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Allergies (list)	Medications (list)	Supplements (list)
____________________	________________________	________________________________
____________________	________________________	________________________________
____________________	________________________	________________________________

INTERESTED IN ALTERNATE HEALING CHOICES?

Nutrition? ☐

Essential Oils? ☐

Acupuncture? ☐