

# CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION	DATE:
Patient Name _____ <small style="margin-left: 350px;">LAST NAME</small>	Employer / School _____
Address _____ <small style="margin-left: 100px;">FIRST NAME</small> <small style="margin-left: 150px;">MIDDLE INITIAL</small>	Occupation _____
City _____ State _____	Spouse's Name _____
Home Phone _____	Do you have Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cell Phone _____	Name of Insurance _____
Email _____	<b>IN CASE OF EMERGENCY, CONTACT</b>
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthday _____	Name _____
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor	Relationship _____
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered	Contact Number _____
	Who may we thank for referring you? _____

**HOW CAN WE HELP YOU? Have you seen a chiropractor in the past?  Yes  No**

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 \_\_\_\_\_

LONGTERM \_\_\_\_\_

## CHILDREN & PREGNANCY

How many children do you have? \_\_\_\_\_ Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Childrens' ages? \_\_\_\_\_ Number of past pregnancies? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_