CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City_____ State_____ ZIP_____

Home Phone _____

Cell Phone _____

Email _____

Sex O M O F SSN_____Birthday_____

0 Married O Widowed O Single O Minor

O Separated O Divorced O Partnered

Employer/School_____

Occupation_____

Spouse Name_____

Spouse Employer_____

Spouse Occupation_____

Emergency Contact:
Name_____
Relationship _____
Contact Number_____

Who may we thank for referring you?_____
May we use your name when contacting the person who referred you? Y / N

HOW CAN WE HELP YOU?

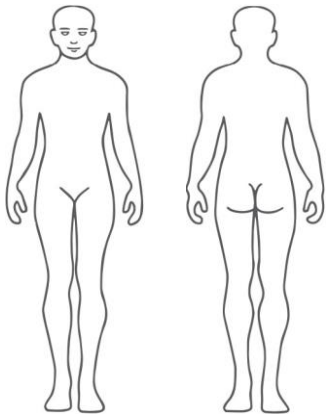
What brings you in today? _____

_____

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)

0	Numbness	0	Sharp
0	Tingling	0	Shooting
0	Stiffness	0	Burning
0	Dull	0	Throbbing
0	Aching	0	Stabbing
0	Cramping	0	Swelling
0	Nagging	0	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	0	0	0	0	Energy	0	0	0	0
Exercise	0	0	0	0	Attitude	0	0	0	0
Recreation	0	0	0	0	Patience	0	0	0	0
Relationships	0	0	0	0	Productivity	0	0	0	0
Sleep	0	0	0	0	Creativity	0	0	0	0
Self-Care	0	0	0	0	Other _____	0	0	0	0

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

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? D No D Yes, I am due____ _

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

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

_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For office use only:

Intermidiate _____

Short Term _____

Long Term _____