

**CHIROPRACTIC INTAKE**

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| **WELCOME** |

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| **PATIENT INFORMATION** | | |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this a Home, Work or Cell Phone? *(please circle)* | | |
| E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Whom may we thank for referring you to our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **IN CASE OF EMERGENCY, PLEASE CONTACT:** | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PATIENT CONDITION** |
| Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is this condition due to a Work Injury or Motor Vehicle Accident? YES or NO *(please circle)\** |
| ***\*if yes please inform receptionist prior to continuing paperwork*** |
| When did your symptoms first appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is this condition getting progressively worse? YES or NO *(please circle)* |
| Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Type of pain: Sharp Dull Throbbing Aching Tingling Numbness Burning Stiffness *(please circle)* |
| How often do you have this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is it constant or does it come and go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does it interfere with your: Work Sleep Daily Routine Recreation *(please circle)* |
| Is there anything that makes the condition worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is there anything that makes the condition better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **HEALTH HISTORY** | | | |
| Have you received any other treatment for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Have you ever been to a Chiropractor? YES or NO When was your last treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Are you pregnant? YES or NO Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Please list any past major surgeries or injuries that you have had and the date: | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ***CONTINUE INTAKE ON NEXT PAGE*** | | | |
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| **HEALTH HISTORY CONTINUED** | | | |
| Please draw a circle to indicate if you have had any of the following: | | | |
| AIDS/HIV | Alcoholism | Allergy Shots | Anemia |
| Arthritis | Asthma | Bleeding Disorders | Cancer |
| Chemical Dependency | Chicken Pox | Diabetes | Epilepsy |
| Goiter | Gout | Heart Disease | Hepatitis |
| Herniated Disc | High Blood Pressure | High Cholesterol | Kidney Disease |
| Liver Disease | Migraine Headaches | Miscarriage | Mononucleosis |
| Multiple Sclerosis | Osteoporosis | Pacemaker | Pneumonia |
| Prostate Problems | Psychiatric Care | Rheumatoid Arthritis | Stroke |
| Suicide Attempt | Tumors, Growths | Thyroid Problems | Ulcers |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **MEDICATIONS** | **ALLERGIES** | **VITAMINS/HERBS/MINERALS** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **SOCIAL HISTORY** | | |
| **EXERCISE** *(please circle)* | **WORK ACTIVITY** *(please circle)* | **HABITS** *(please circle)* |
| None | Sitting | Smoking Packs/Day \_\_\_\_\_\_\_\_\_\_\_ |
| Moderate | Standing | Alcohol Drinks/Week \_\_\_\_\_\_\_\_\_ |
| Daily | Light Labor | Coffee/Caffeine Cups/Day \_\_\_\_\_\_\_\_\_\_\_ |
| Heavy | Heavy Labor | High Stress Levels Reason \_\_\_\_\_\_\_\_\_\_\_\_\_ |

***I attest that the above information is true to the best of my knowledge:***

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_