Safe Harbor
Chiropractic, PC

PATIENT INTAKE FORM

Name: _____ **Date**: _____
Address: _____
Cell Phone: _____ **Home Phone**: _____ **Work Phone**: _____
Email: _____
Date of Birth: _____ **Age**: _____ **Sex**: _____
Occupation: _____
Highest Level Education Completed: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Partner [ ] Widowed
Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Student [ ] Other

Health History

Is your present injury/concern due to a car accident or a work-related injury? **YES or NO**
Have you had previous chiropractic care? **YES or NO**
If yes, please explain type of care:

Were you pleased with your chiropractic care? **YES or NO**

Reasons for seeking chiropractic care:

When did this concern/problem begin? _____
Had you had this before? _____
Is it getting: **BETTER WORSE NO CHANGE**

Other providers seen for this condition, outcomes, and treatment:

"For I know the plans I have for you... plans to give you hope for the future."
- Jeremiah 29:11

Medications & Supplements

Current medications (reason & duration of time)

Current nutritional supplements (reason & length of time)

(Check all that apply)

[ ] Arthritis	[ ] Hypertension
[ ] Cancer	[ ] Psychiatric Illness
[ ] Fibromyalgia	[ ] Diabetes
[ ] Skin Disorders	[ ] Asthma
[ ] Heart Disease	[ ] Stroke
[ ] Osteoporosis	[ ] Other: _____

Please list ALL surgeries:

(Check all that apply)

[ ] Appendectomy	[ ] Cervical Spine Surgery
[ ] Joint Replacements	[ ] Thoracic Spine Surgery
[ ] Brain Surgery	[ ] Lumbar Spine Surgery
[ ] Carpal Tunnel Release	[ ] Urogenital Surgery
[ ] Breast Augmentation	[ ] Hysterectomy
[ ] Cardiovascular Procedure	[ ] Gallbladder Surgery
[ ] Prostate Surgery	[ ] Knee Surgery
[ ] Shoulder Surgery	[ ] Hip Surgery
[ ] Gastrointestinal Procedures	[ ] Hernia Repair
	[ ] Other: _____

Allergies

(Check all that apply)

[ ] Seasonal [ ] Mold [ ] Sulfites [ ] Milk/Lactose [ ] Wheat [ ] Animal [ ] Other: _____

Social History

(Check all that apply)

ACTIVITY	NEVER	OCCASIONAL	OFTEN
Caffeine Use			
Alcohol			
Exercise			
Drinking Water			
Cigarettes / Vape			
Sleep			
Other: _____			

Family History

(Check all that apply)

CONDITION	PARENT	SIBLING
Arthritis		
Cancer		
Diabetes		
Heart Disease		
Hypertension		
Stroke		
Thyroid		

Occupational Activities

(Circle all that apply)

Administration	Business Owner	Clerical / Secretary	Computer Use
Construction	Day Care/Child Care	Executive / Legal	Food Service Industry
Health Care	Heavy Equipment	Heavy Manual Labor	Manufacturing
Home Services	Housekeeper	Other: _____	

Women Only

Date of last menstrual period: _____

Do you experience: [ ] Pain [ ] Heavy [ ] Clotting [ ] Bowel Changes [ ] Migraines
[ ] Leg Weakness [ ] Fatigue

Abnormal Pap or Mammogram: **YES or NO** if yes, Date: _____

Do you experience any of the following symptoms: [ ] Hot Flashes [ ] Night Sweats
[ ] Insomnia [ ] Memory Loss [ ] Mood Swings [ ] Low Sex Drive [ ] Breast Tenderness
[ ] Weight Gain [ ] Anxiety [ ] Other: _____

Men Only

Do you experience any of the following symptoms:

[ ] Decreased Urinary Flow [ ] Irritability [ ] Erectile Dysfunction [ ] Abdominal Weight Gain [ ] Loss of Muscle Tone [ ] Difficulty Concentrating

Other: _____

Date of last prostate exam: _____
Results: _____

Patient Certification

I certify that the information provided is accurate and complete to the best of my knowledge.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

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"He heals the brokenhearted and binds up their wounds."
- Psalm 147:3