

CHIROPRACTIC INTAKE & HISTORY

Date _____

Patient Name _____

Phone _____

Address _____

Email _____

City _____ State _____

Sex M F Age ____ Birthday _____

Employer/Occupation _____

Complaint

When did it start? _____ Have you had this condition before? _____

Was this condition a result of an auto accident, work accident or other _____

Have you had previous chiropractic care? _____ Date of last visit _____

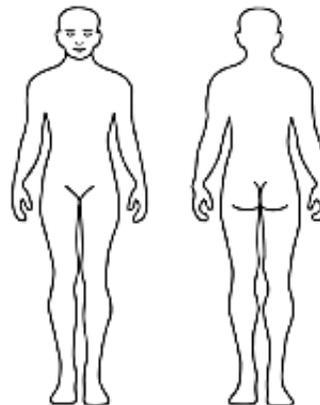
How bad is it? How Intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
 NO SYMPTOMS INTENSE SYMPTOM

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

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
<small>(Constipation/Diarrhea/GERD/IBS)</small> | <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

Medications

Supplements

Notes: