Patient Name:_____ Date:_____

Chiropractic Intake Form

Chief Complaint:

What brings you to the office today? _____

When did it begin? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

Please explain: _____

How are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

Are you currently or have you previously been treated for this problem? ☐ Y ☐ N

By whom: _____

Type of Treatment: _____

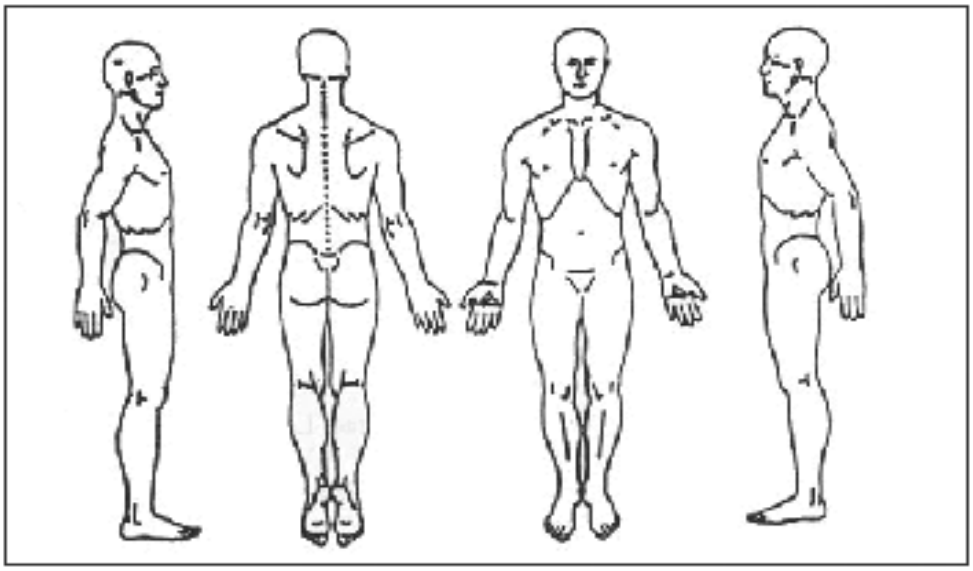
Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other _____

To who have you reported your accident?

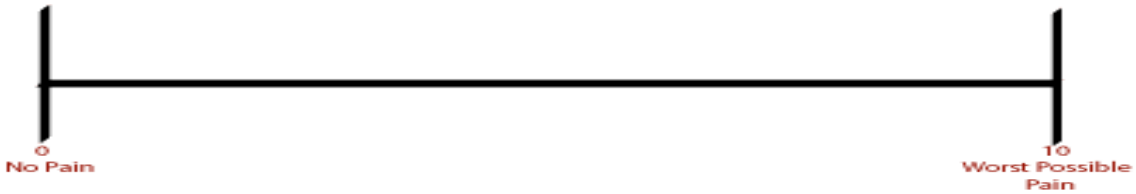
☐ Auto Insurance ☐ Employer ☐ Workers Comp. ☐ Other _____

Attorney Name (if applicable): _____



Please draw location and type of pain on body outline.

Ache ^^^^^^ ^^^	Burning = = = = = = = = = =
Numbness ooooooo oooo	Pins and Needles ……. …….
Stabbing //////// ////	Other xxxxxx xxx



Please indicate level of pain on line with a mark

How often do you experience your symptoms?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

Have you had these symptoms in the past? ☐ Yes ☐ No

Have you had any testing for your condition?

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Other _____

When were these tests performed? _____

Dr.'s Initials: _____

Patient Name:_____ Date:_____

Health History/Medical Conditions: Have you had any of the following

□ Alcoholism	□ Drug Dependence	□ Hypertension	□ Prostate Disease
□ Anemia	□ Emphysema	□ High Cholesterol	□ Prosthesis
□ Anorexia/Bulimia	□ Epilepsy	□ Kidney Disease	□ Psychiatric Illness
□ Asthma	□ Eye Condition	□ Liver Disease	□ Sinus Problems/Allergies
□ Arthritis	□ Excessive Thirst	□ Lupus	□ Scoliosis
□ Back/Neck Condition	□ Fibromyalgia	□ Lyme Disease	□ Skin Disorder
□ Bladder/Bowel Change	□ Fractures	□ Miscarriage	□ Stroke
□ Bleeding Disorder	□ Frequent Urination	□ Multiple Sclerosis	□ Thyroid Problem
□ Breast Lump	□ Gall Bladder Disease	□ Neurologic Condition	□ Tuberculosis
□ Cancer	□ Gout	□ Osteoporosis	□ Ulcers
□ Chemical Dependency	□ Headaches	□ Pacemaker	□ Urinary Tract Infections
□ Chicken Pox	□ Heart Disease	□ Parkinson's Disease	□ Vascular Disease
□ Depression/Anxiety	□ Hepatitis	□ Pinched Nerve	□ Venereal Disease
□ Diabetes	□ Hernia	□ Polio	□ Weight gain/Loss
□ Dizziness	□ Herniated Disk	□ Pregnancy	□ Other_____

Surgical History

□ Abdominal/Gastrointestinal	□ Gynecological/Genitourinary	□ Prostate
□ Back Surgery	□ Joint Procedure	□ Skin Procedure
□ Cardiovascular Procedure	□ Neck Surgery	□ Other _____

Please describe any hospitalizations or surgeries below (please include approximate date):

_____

_____

_____

Allergies:

□ Environmental	□ Food	□ Seasonal
□ Latex	□ Medications	□ Other _____

Please describe allergies below:

_____

_____

Social History

Personal Habits:

Have you ever smoked? □ Yes □ No For how long?
_____

- □ Tobacco packs/day _____
- □ Alcohol drinks/wk _____
- □ Coffee/tea/cola cups/day _____
- □ Recreational drugs times/wk _____

Stress level

□ Mild □ Moderate □ Severe

Any dietary restrictions?
If yes, describe
_____
_____

Work Activity Level

- □ Sitting % of time _____
- □ Standing % of time _____
- □ Light Labor % of time _____
- □ Heavy Labor % of time _____

Exercise

Do you exercise regularly? □ Y □ N
If yes, describe routine and how often: _____
_____
_____
_____
_____
_____

In general how is your overall health right now? □ Excellent □ Very Good □ Good □ Fair □ Poor

Dr.'s Initials: _____

Patient Name:_____ Date:_____

Family History

- ☐ Arthritis
- ☐ Heart Problems
- ☐ Thyroid
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Psychiatric
- ☐ Stroke
- ☐ Other _____

Please describe below

_____

_____

Medications & Supplements

Please list any medications and supplements you are currently taken or have used in the last 90 days.

Medications	Supplements

Occupation:

- ☐ Professional/Executive
- ☐ White Collar/Secretarial
- ☐ Laborer
- ☐ Tradesperson
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Other _____

- ☐ Full-Time
- ☐ Part-Time
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Off Work
- ☐ Other _____

Please describe daily work activities:

_____

_____

_____

Is there anything else the doctor should know about your current condition or your health history that has not already been covered?

_____

_____

_____

_____

_____

_____

Dr.'s Initials: _____

Thank You. Please return to the front desk.