

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME
FIRST NAME MIDDLE INITIAL
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ☐ M ☐ F Age _____ Birthday _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

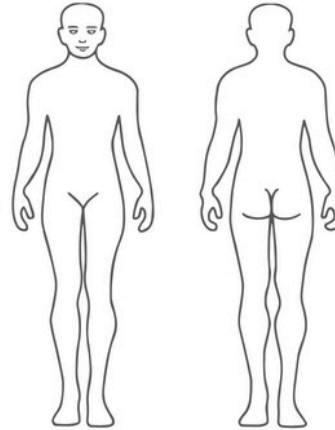
How bad is it? How intense are your symptoms? (circle)

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)

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

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



On the arrow diagram above:

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

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

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

PAST INJURIES

List any past auto collisions: _____ Was any care received? _____

List any past work injuries: _____ Was any care received? _____

List any past sport, recreational, or home injuries: _____

Please describe any past conditions and treatment received: _____

Please list any past hospitalizations and surgeries: _____

HEALTH & ILLNESS HISTORY

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

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

