Name:_____

CHIROPRACTIC INTAKE FORM

IS THIS RELATED TO A:

1. Recent motor vehicle accident Yes No (if Yes to either, inform Reception
2. Work related injury/accident Yes No immediately)

Prior Care:

Have you ever had X-Rays/CT/MRI: Yes No

(if Yes)Date:_____Area of the body:_____

Date:_____Area of the body:_____

PRIMARY CONCERNS

Primary Complaint:_____

_____

_____

Date Problem began: _____

What makes it worse? _____

_____

What makes it better?_____

_____

Describe this concern/discomfort (aching, stabbing, numbness, etc.)_____

_____

At this time I rate this concern at:

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Is this concern: Constant Frequent Occasional (please circle one)

What time of day is it worst?_____

Anything else you would like to say about this concern?_____

_____

Any other practitioners seen for this concern?_____

Your expectations regarding this concern:_____

_____

Is this concern limiting you in any way?_____

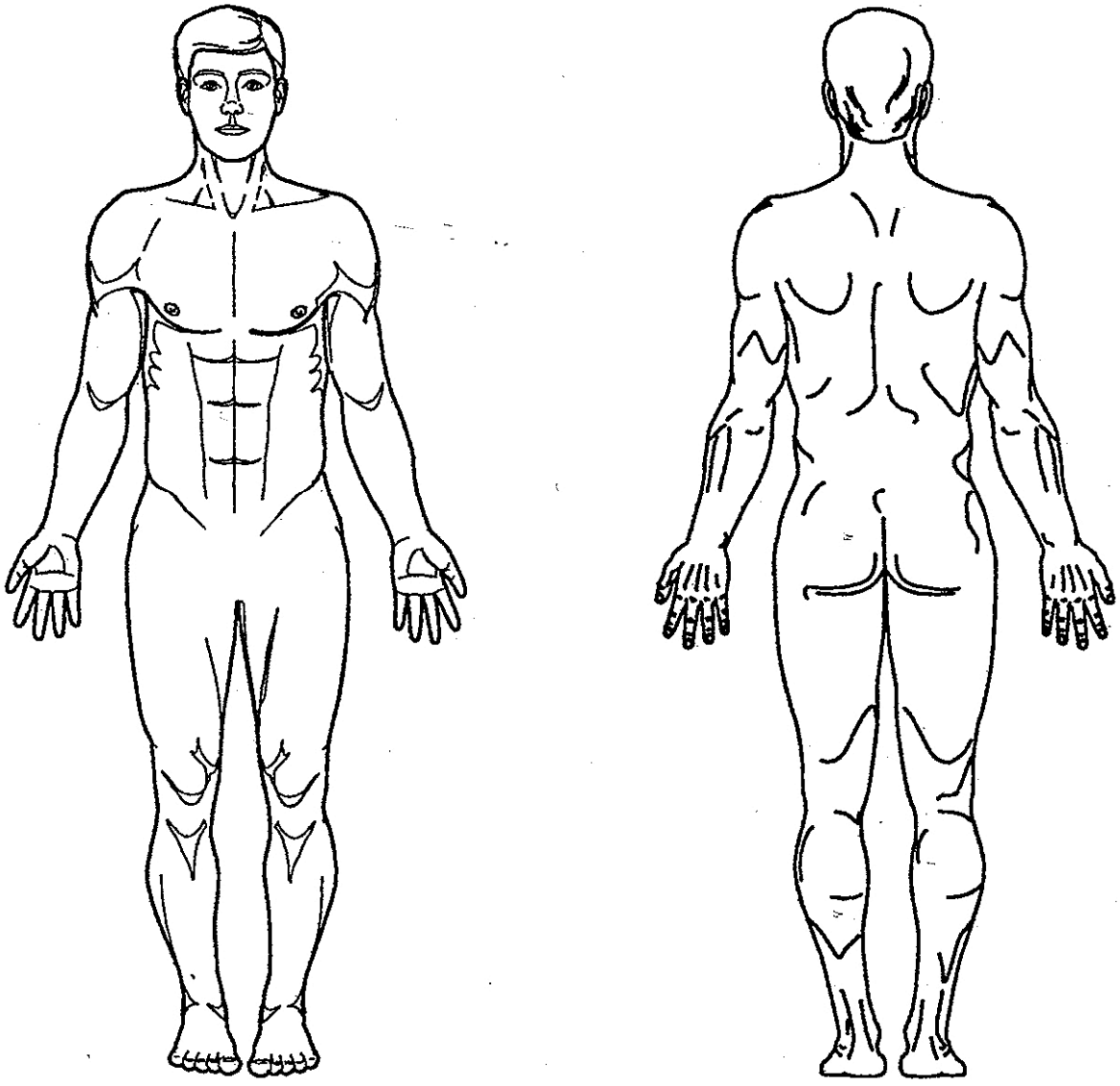
Name:_____

PATIENT PRESENT SYMPTOMS

Show area (s) of pain or unusual feelings:

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
.....	000000000	XXXXXX	******	///////////



Name:_____

PAST HISTORY

Have you ever suffered from (tick all that apply)

Dizziness	□ Yes	□ No	Headaches	□ Yes	□ No
Heart Trouble	□ Yes	□ No	Asthma	□ Yes	□ No
Heartburn	□ Yes	□ No	Digestive Problems	□ Yes	□ No
Sinus Trouble	□ Yes	□ No	Menstrual Problems	□ Yes	□ No
Cancer	□ Yes	□ No	Depression	□ Yes	□ No
Numbness	□ Yes	□ No	Deafness	□ Yes	□ No
Ear Noises	□ Yes	□ No	High blood Pressure	□ Yes	□ No
Bruise easily	□ Yes	□ No	Menopausal	□ Yes	□ No

Please list any operations with dates: _____

Please list any major illnesses with dates:_____

Any other hospitalizations:_____

Please list any family health conditions (i.e. arthritis, diabetes, cancer, heart disease):___

_____

Car Accidents (including dates and injuries): _____

_____

Other Accidents/Falls:_____

Emotional traumas:_____

Knocked unconscious or concussions: Yes No Date:_____

Rate your quality of health: Excellent Good OK Poor Terrible

List any sports, exercises, and common activities you do:_____

_____

Have you ever had Chiropractic care before: Yes No When? _____

Marital Status: _____Partner's Name:_____

Children's Names & Ages:_____

Pregnant: Yes___ No___ Due Date:_____ (If Yes, Please inform the Doctor)

Occupation:_____City:_____