Date _____

CONFIDENTIAL INTAKE FORM

Please fill out the following form in as much detail as possible.

Name _____SS#_____

Email _____

Address _____

Home Phone _____ Cell Phone _____

Age _____ Date of Birth_____ Occupation _____ Sex M F

Height _____ Weight _____ Referred by _____

Employer _____ Address _____

Marital Status M S W D Children _____ Name of Spouse _____

Is any member of your family treated in the office? _____

Have you ever had chiropractic care before? _____ Where? _____

For what problem? _____
Were the results satisfactory Yes No

What are your health goals?

_____
_____
_____

Major complaints and symptoms—please be as specific as you can. Ask the doctor for help if you need assistance in filling out this section.

_____
_____
_____
_____
_____

How do you believe your problem (pain) began?

_____
_____
_____

When did you first notice this problem/pain?

_____

Have you lost any work? Yes No Day and date you last worked _____
Have you ever had this condition before or a similar condition? Yes No When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you been treated by a medical physician for this ailment? Yes No Where? _____

Describe the previous treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Emergency Contact
Person's Name _____ Phone _____

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? _____

When & What _____

Are you allergic to anything that you are aware of: _____

Are you presently taking any medication (aspirin included) Yes No

If Yes, please name them _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Give dates you have had any of the following? (if exact date unknown, give approximate date)

Blood Tests _____ Urinalysis _____

X-ray examination _____ Other special treatment _____

At what hospital or office were these tests taken? _____

Name of doctor who ordered tests? _____

Date of last menstrual period _____ Are you may pregnant? Yes No If so, due date _____

Do you have any health problems not listed above? _____

Have you ever had cancer? Yes No Where? _____

Does your pain wake you from a sound sleep? Yes No
Have you lost or gained weight in the past year? Yes No

Habits (please check)

Cigarettes? _____ Quantity _____ Hobbies _____

Coffee? _____ Quantity _____ Do you take vitamins? Yes No

Alcohol? _____ Quantity _____ If yes, please list them: _____

Tea? _____ Quantity _____ _____

Use this space for any additional information you may wish to discuss _____

_____

_____

_____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? (please mark as follows) N = Now H = Had

Headaches _____	Frequency _____	Shortness of Breath	_____	Stomach Upset	_____
Neck Pain	_____	Fatigue	_____	Constipation	_____
Stiff Neck	_____	Depression	_____	Cold Sweats	_____
Sleeping Problems	_____	Lights Bother eyes	_____	Fever	_____
Back Pain _____	Where _____	Loss of Memory	_____	Sinus problems	_____
Nervousness	_____	Ears Ringing	_____	Diabetes	_____
Tension	_____	Face Flushed	_____	Hemorrhoids	_____
Irritability	_____	Buzzing in Ears	_____	Leg Cramps	_____
Chest pains	_____	Loss of Balance	_____	Colitis	_____
Dizziness	_____	Fainting	_____	Gall Bladder	_____
Shoulder/Neck/Arm Pain	_____	Loss of Smell	_____	Indigestion	_____
Pins & Needles in Arms	_____	Loss of Taste	_____	Belching	_____
Pins & Needles in Legs	_____	Diarrhea	_____	Vomiting	_____
Numbness in Finger	_____	Feet Cold	_____	Shoulder Pain	_____
Numbness in Toes	_____	Hands Cold	_____	Swollen Joints	_____
High Blood Pressure	_____	Arthritis	_____	Knee Pain	_____
Difficulty Urinating	_____	Muscle Spasms	_____	Hayfever	_____
Allergies	_____	Where_____		Menstrual Difficulties	____
Weakness in Arms	_____	Frequent Colds	_____		
Weakness in Legs	_____				

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself and that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Printed name _____