UNITY
WELLNESS

ADULT CHIROPRACTIC INTAKE

Office Use Only
Reviewed: _____

Name: _____ Date of Birth: _____

Occupation: _____

Is this part of a Worker's Compensation Case? ☐ No ☐ Yes- Date of Accident: _____

Is this part of a Motor Vehicle Accident? ☐ No ☐ Yes- Date of Accident: _____

☐Correct and/or prevent an existing problem ☐ Health and spinal check-up

Please fill out the information below

NATURE OF THE COMPLAINT

Symptoms and/or main problem: _____

How and when problem started: _____

How often are your symptoms present?

☐ Constant (75-100% of the time) ☐ Frequently (50-75% of the time)
☐ Occasionally (< 50% of the time) ☐ Intermittently (comes and goes)

Since the problem started, it is: ☐ Getting better ☐ Getting worse ☐ Staying the same

Circle the number out of 10 that describes the intensity of your pain. If it varies, circle the numbers that describe the symptoms at their **best** and **worst**:

1 2 3 4 5 6 7 8 9 10

Words that describe your pain/symptoms:

☐ Sharp ☐ Dull/Aching ☐ Throbbing ☐ Radiating, to: _____
☐ Numb ☐ Tingling ☐ Burning ☐ Shooting, to: _____
☐ Other _____

Aggravating factors: _____

Relieving factors: _____

Please describe any treatments and/or tests done for this problem: _____

_____

This problem interferes with: ☐ Sleep ☐ Work ☐ Routine ☐ Other: _____

Have you had x-rays taken of the area? ☐No ☐Yes and when: _____

Briefly describe any other complaints: _____

HEALTH HISTORY

Check off ANY of the following symptoms you currently have or have had in the past **6 MONTHS**:

- ☐ Headaches
- ☐ Leg/knee/foot pain
- ☐ Dizziness
- ☐ Allergies
- ☐ Frequent nausea
- ☐ Anxiousness
- ☐ Arthritis
- ☐ IBS/Colitis
- ☐ Jaw pain
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Chest pain
- ☐ Sinus problems
- ☐ Cold feet/hands
- ☐ Miscarriage(s) _____
- ☐ Sleep problems
- ☐ Painful urination
- ☐ Liver/gallbladder disease
- ☐ Diarrhea/constipation
- ☐ Arm/shoulder/wrist pain
- ☐ Buzzing/ringing in ears
- ☐ General fatigue
- ☐ Heartburn/indigestion
- ☐ Menstrual pain/PMS
- ☐ Thyroid problems
- ☐ High cholesterol
- ☐ Depression
- ☐ Low back/hip pain
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Frequent colds
- ☐ Sexual dysfunction
- ☐ Breast pain
- ☐ Asthma
- ☐ Numbness/tingling
- ☐ Cancer _____

Medical Conditions: _____

_____

Medications and/or supplements: _____

_____

Surgeries/hospitalizations and when: _____

Recent trauma, car accidents, falls, or injuries and when: _____

_____

Have you had your bone density checked? ☐ No ☐ Yes, when: _____

Family history of: ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Diabetes

Anything else you'd like us to know: _____

_____