

CHIROPRACTIC INTAKE & HISTORY



PATIENT INFORMATION

Patient Name _____
LAST NAME

FIRST NAME MIDDLE INITIAL

Address _____
 City _____ Province _____

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? _____

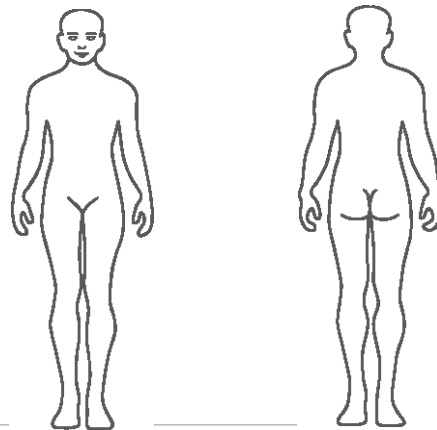
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) **1 2 3 4 5 6 7 8 9 10**
No Symptom Intense symptom

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramping
- Nagging
- Sharp
- Shooting
- Burning
- Throbbing
- Stabbing
- Swelling
- Other _____



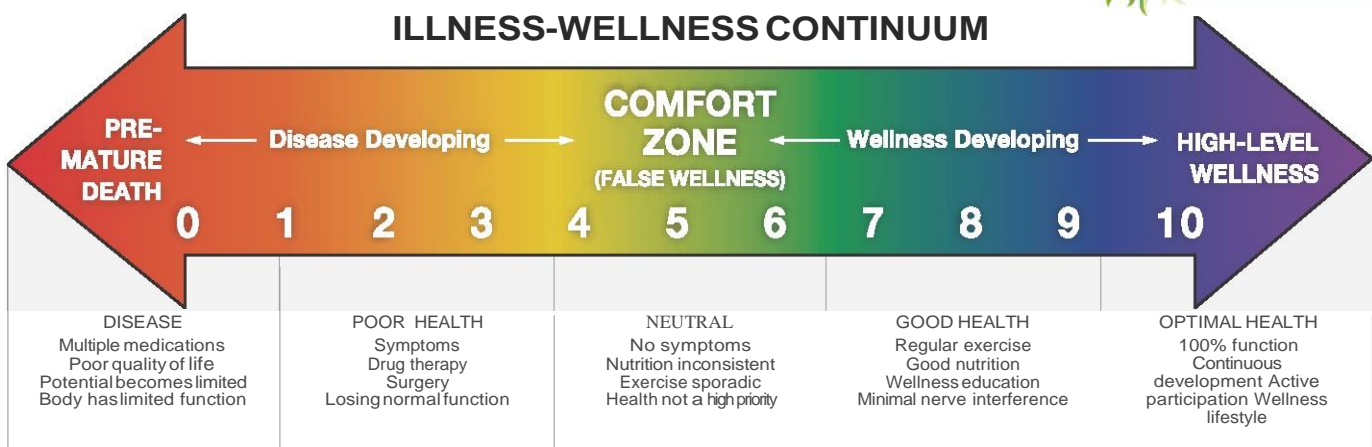
IMPACT OF YOUR SYMPTOMS

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Attitude	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recreation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Patience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Productivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Creativity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How committed are you to correcting this issue? **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 _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? No Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

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

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

