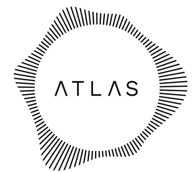
Chiropractic Intake and History



Date:

PATIENT INFORMATION

Patient Name:

Address:

Home phone: | ID / Passport Number:

Mobile number: | Email:

DOB (DD/MM/YY): | Age: | Gender: M ☐ / F ☐

Marital status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Occupation: | Employer / School:

Spouse / Guardian name: | Spouse's Employer and Occupation:

In case of emergency, please contact

Name: | Relationship: | Contact number:

Who may we thank for referring you?

HOW CAN WE HELP YOU?

What brings you in today?

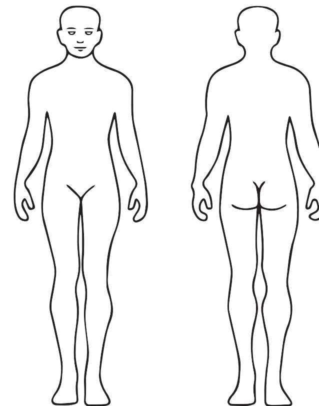
If you are already experiencing symptoms, what are they?

How bad is it? How intense are your symptoms? No Symptoms (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Intense Symptoms

Please cirlce the 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 (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? Not Committed (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Very Committed

PATIENT WELLNESS ASSESSMENT

Illness Wellness Continuum

-10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8 9 10

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

ON THE ARROW DIAGRAM ABOVE

A. What do you think represents your health?

B. In what direction is your health currently headed?

WHAT ARE YOUR HEALTH GOALS?

Immediate

Short Term

Long Term

CHILDREN AND PREGNANCY

How many children do you have?	Are you currently pregnant? Yes ☐ / No ☐
Children's ages?	Number of past pregnancies?
Children's health concerns?	Health concerns regarding this pregnancy?

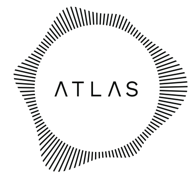
HEALTH AND ILLNESS HISTORY

☐ 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 AND SUPPLEMENTS

Allergies (list)	Medications (list)	Supplements (list)

Current & Progress Questionnaire



Our goal is to give you the highest quality health care imaginable for your overall health, well being and quality of life!

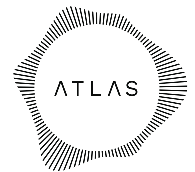
Name:

HEALTH CONCERNS: Please rate your health concerns on a 0-10 scale; in which 0 is Mild and 10 is WORST imaginable	FIRST EVALUATION	PROGRESS 1	PROGRESS 2	PROGRESS 3
1.				
2.				
3.				
4.				
I would rate the overall movement and flexibility in my neck 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my mid back 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my low back 10 = flexible, 0 = rigid				
My overall posture & ease in standing straight 10 = great, 0 = terrible				
I sleep deep and wake up feeling rested 10 = rested, 0 = tired				
I feel I have energy for all my daily activities 10 = a lot, 0 = none				
How I cope with emotional stress 10 = excellent, 0 = terrible				
Any new health concerns since last evaluation: 0 = **MILD** and 10 = **WORST**				
1.				
2.				
My awareness of what my body wants from me in relation to e.g. sleep, rest , exercise, movement, diet, since receiving adjustments 10 = Yes, 0 = No				
I feel negative emotions like anger, depression, unhappy, hopeless 0 = no anger , 10 = severe anger				
I feel positive emotions like joy, happiness, gratitude, hope 10 = a lot of joy, 0 = no joy				
My diet is 10= excellent, 0 = terrible				
My exercise is 10 = excellent, 0 = none				
Are you continuing your lifestyle changes?				

WHAT ARE YOUR HEALTH GOALS AT THIS POINT? (FOR FIRST EVALUATION)

☐ Correct symptoms. ☐ Improve function of body. ☐ Stay healthy to avoid currently or other health issues.

Current & Progress Questionnaire



Name:

HEALTH CONCERNS: Please rate your health concerns on a 0-10 scale; in which 0 is Mild and 10 is WORST imaginable	PROGRESS 4	PROGRESS 5	PROGRESS 6	PROGRESS 7
1.				
2.				
3.				
4.				
I would rate the overall movement and flexibility in my neck 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my mid back 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my low back 10 = flexible, 0 = rigid				
My overall posture & ease in standing straight 10 = great, 0 = terrible				
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My diet is 10= excellent, 0 = terrible				
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Are you continuing your lifestyle changes?				

OUR GOAL IS FOR YOU TO **"BECOME WELL AND STAY WELL"**