CHIROPRACTIC INTAKE & HISTORY

HILL FAMILY CHIROPRACTIC
ELEVATION HEALTH CENTER

Appt Date:_____

PATIENT INFORMATION

How did you hear about us? ☐ **Website** ☐ **Facebook** ☐ **Event**_____ ☐ **Referral:**_____

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City_____State _____Zip:_____

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 _____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number _____

HOW CAN WE HELP YOU?

What brings you in today? ___ _____

_____

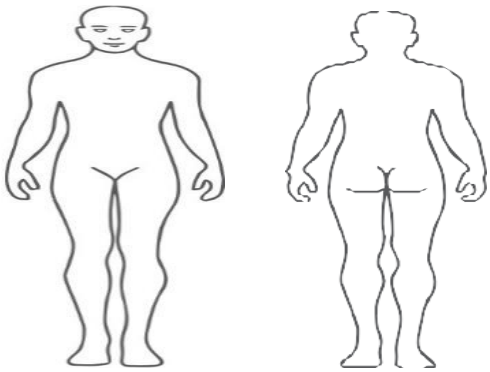
Additional health concerns: ___ _____

_____

How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please mark the areas on the body diagram with the following letters to describe your symptoms:



R= **R**adiating **A**=**A**ching **T**=**T**ingling

B=**B**urning **N**=**N**umbness

D=**D**ull **S**=**S**harp/**S**tabbing

Hx Trauma

Motor Vehicle Accidents:

_____

Work: _____

_____

Sports: _____

_____

Children/Pregnancy: _____

_____

Misc.: _____

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	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITED

10 = VERY COMMITED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

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 _____

Goals

Where on the wellness continuum would you like to be? _____

_____

How long do you think that will take? _____

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

Check the box on any condition that you have had and circle current ones.

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

Patient or Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature: _____ Date Form Reviewed: _____/_____/_____