

Please fill out the following information as thoroughly as possible.

Personal Information:

Name _____ Phone _____

City _____ State _____ Zip _____ Date of Birth ____ / ____ / ____

Today's Visit:

What brings you to our office today?

What seems to relieve your symptoms?

What seems to make them worse?

How long have you been dealing with this current issue?

Very Recently

Less than 1 Year

1-3 Years

3+ Years

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= Radiating

A=Aching

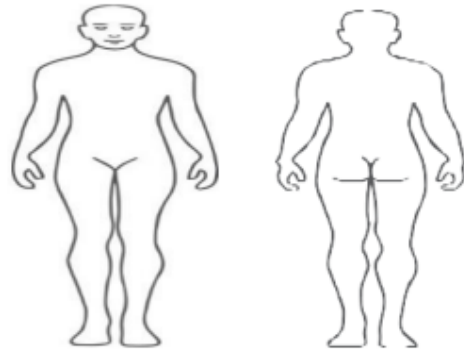
T=Tingling

B=Burning

N=Numbness

D=Dull

S=Sharp/Stabbing



Have you been adjusted by a chiropractor before?

(Circle) YES NO

If so, approximately when was your most recent adjustment?

____ / ____
MO YR

How would you describe your experience?

(Circle) POSITIVE NEGATIVE

Are you under 250lbs?

(Circle) YES NO

How did you hear about our office? (Circle) Google - Facebook - Website - Current Patient:

If so, who? _____

You are Stronger, Healthier, and Happier at Hill Family Chiropractic!



INTAKE

For Doctor Use

	Occiput L/R			T9	
	Cervical 1 – L/R			T10	
	C2			T11	
	C3			T12	
	C4			Lumbar - 1	
	C5			L2	
	C6			L3	
	C7			L4	
	Thoracic – 1			L5	
	T2			L6	
	T3			SI Joint L/R	
	T4			Sacrum 1	
	T5			S2	
	T6			S3	
	T7			S4/S5	
	T8			Ilium	

BACK ON TRACK ____ SESSIONS _____ IN ____ MIN (CIRCLE) C L

LASER ____ SESSIONS (CIRCLE) ACUTE SUB-ACUTE CHRONIC | HIGH MED LOW

AREA _____

Additional Notes:
