

CHIROPRACTIC INTAKE & HISTORY



Appt Date: _____

PATIENT INFORMATION

How did you hear about us? Website Facebook

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

Event _____ Referral: _____

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= Radiating

A=Aching

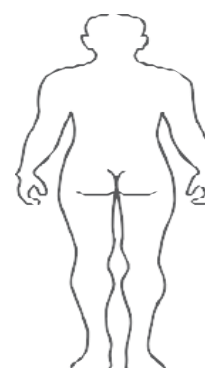
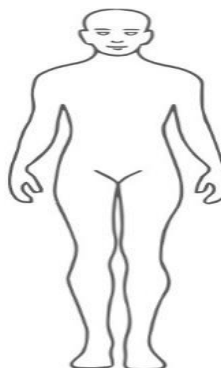
T=Tingling

B=Burning

N=Numbness

D=Dull

S=Sharp/Stabbing



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

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
 NOT COMMITTED VERY COMMITTED

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? _____ Are you currently pregnant? No Yes, I am due _____
Childrens' ages? _____ Number of past pregnancies? _____
Childrens' health concerns? _____ Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in 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/GERD/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)

Patient or Guardian's Signature: _____ Date: ____/____/____

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

