CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

DATE:

Patient Name _____

_____

Address _____

City _____ State Zip _____

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 _____

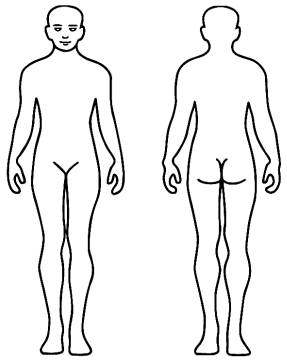
Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

☐ MAIN Concern(s): _____

_____

- When did it (they) start? _____
- How bad is it? How intense are your symptoms? (circle) **No Symptoms 1 2 3 4 5 6 7 8 9 10 Severe Symptoms**
- Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Tingling ☐ Sharp

☐ Shooting ☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing ☐ Stabbing

☐ Aching ☐ Cramping ☐ Swelling

☐ Nagging ☐ 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	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	_____ OTHER	☐	☐	☐	☐