



# Patient Intake Form

## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
(First) (Middle) (Last)

Home Address \_\_\_\_\_ Work Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

### If under 18, please include Parent's name and address:

Parent's Name \_\_\_\_\_

Home Address \_\_\_\_\_ Work Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

**Sex:**  Male  Female

**Marital Status:**  Single  Married  Widowed

Age \_\_\_\_\_ Number of Children \_\_\_\_\_ Age(s) of Children: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Reason for consulting our office? \_\_\_\_\_

\_\_\_\_\_

### Referred to this clinic by:

Friend

Relative

Telephone Directory

Doctor of Chiropractic

Medical Doctor

Other

Whom may we thank for referring you to our office? \_\_\_\_\_

If referred by another doctor,

Please provide doctor's name & clinic \_\_\_\_\_

## Employment Information

Employment Status:  Fulltime  Part-Time  Not Employed  Retired

Occupation \_\_\_\_\_

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

## Health Profile

### Childhood Years (to age 17)

Research is showing that many of the challenges that occur later in life have their origins during the developmental years (some starting at birth). Please answer the following questions to the best of your ability.

	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you fallen/jumped from a height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you experience any adverse reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
over three feet? (i.e. crib,bunk bed,trees)				to the vaccination(s)?			
Were you involved in any car accidents as	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a child?				chiropractic care?			
				Was your birth traumatic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

### Adult Years (age 18 to present)

	Yes	No	Unsure		Yes	No	Unsure
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1-10, describe your stress			
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	level (1=none, 10=extreme):			
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____			
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal _____			

On a scale of Poor, Good, Excellent, describe your:

Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

If you have no symptoms or complaints and are here for wellness services, please check (✓) here \_\_\_\_ (Wish to have Chiropractic Wellness Services) and skip to the Family Health Profile. Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it:  Sharp  Dull  Comes and goes  Travels  Constant

Since the problem started, it is:  About the same  Getting Better  Getting worse

What makes it worse? \_\_\_\_\_

It interferes with:  Work  Sleep  Walking  Sitting  Hobbies  Leisure

## Health Profile Continued

Other Doctors seen for this problem (please list)

- |                                               |                                                   |
|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Chiropractor _____   | <input type="checkbox"/> Physical Therapist _____ |
| <input type="checkbox"/> Medical Doctor _____ | <input type="checkbox"/> Massage Therapist _____  |
| <input type="checkbox"/> Acupuncturist _____  | <input type="checkbox"/> Other _____              |

Please check (✓) all the conditions that you have experienced in the last six months, even if they do not seem related to you current problem.

- |                                                       |                                                         |                                                            |                                                 |
|-------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Jaw Pain                       | <input type="checkbox"/> History of Cancer                 | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Lights bother eyes           | <input type="checkbox"/> Shoulder Pain                  | <input type="checkbox"/> Past/ Current Medical Steroid use | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Loss of balance              | <input type="checkbox"/> Elbow Pain                     | <input type="checkbox"/> Cold sweats                       | <input type="checkbox"/> Heartburn              |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Wrist Pain                     | <input type="checkbox"/> Cold hands                        | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Ringing in ears              | <input type="checkbox"/> Hip Pain                       | <input type="checkbox"/> Cold feet                         | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Tingling in face             | <input type="checkbox"/> Knee Pain                      | <input type="checkbox"/> Sleeping problems                 | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Pins and needles in arms     | <input type="checkbox"/> Shin Splints                   | <input type="checkbox"/> Fever                             | <input type="checkbox"/> Heart conditions       |
| <input type="checkbox"/> Numbness in fingers          | <input type="checkbox"/> Ankle Pain                     | <input type="checkbox"/> Over Weight                       | <input type="checkbox"/> Hernia                 |
| <input type="checkbox"/> Pins and needles in legs     | <input type="checkbox"/> Heel Pain                      | <input type="checkbox"/> Under Weight                      | <input type="checkbox"/> Irritability           |
| <input type="checkbox"/> Numbness in toes             | <input type="checkbox"/> Plantar Fasciitis              | <input type="checkbox"/> Fatigue                           | <input type="checkbox"/> Paralysis              |
| <input type="checkbox"/> Problem initiating urination | <input type="checkbox"/> Chronic Cough                  | <input type="checkbox"/> Fibromyalgia                      | <input type="checkbox"/> Tremor                 |
| <input type="checkbox"/> Neck pain                    | <input type="checkbox"/> Coughing up Blood              | <input type="checkbox"/> Chronic Fatigue Syndrome          | <input type="checkbox"/> Menstrual pain         |
| <input type="checkbox"/> Pain Between Shoulder Blades | <input type="checkbox"/> Frequent Urination             | <input type="checkbox"/> Acne                              | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Low Back pain                | <input type="checkbox"/> Losing Weight without trying   | <input type="checkbox"/> Mood swings                       | <input type="checkbox"/> Yeast Infections       |
| <input type="checkbox"/> Loss of Hearing              | <input type="checkbox"/> Recent Bowel/ Bladder Changes  | <input type="checkbox"/> Depression                        | <input type="checkbox"/> Pregnant               |
| <input type="checkbox"/> Loss of smell                | <input type="checkbox"/> Blood in Stool                 | <input type="checkbox"/> Food Allergies                    | <input type="checkbox"/> Hot flashes            |
| <input type="checkbox"/> Loss of taste                | <input type="checkbox"/> Pain that wakes me up at night | <input type="checkbox"/> Seasonal Allergies                | <input type="checkbox"/> Colic (fussy baby)     |
| <input type="checkbox"/> High blood pressure          |                                                         | <input type="checkbox"/> Loss of Sex Drive                 | <input type="checkbox"/> Ear Infections         |
| <input type="checkbox"/> Low blood pressure           |                                                         | <input type="checkbox"/> Sinus Infections                  | <input type="checkbox"/> Bed wetting            |
|                                                       |                                                         |                                                            | <input type="checkbox"/> Other _____            |

List any medications you are taking \_\_\_\_\_

### Family Health Profile:

At our office, we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about you:

- |                |                  |
|----------------|------------------|
| Children _____ | Brother(s) _____ |
| Spouse _____   | Sister(s) _____  |
| Mother _____   | Other(s) _____   |
| Father _____   |                  |

Have you ever:

- Bought bottled water:  Yes  No
- Belonged to a health club:  Yes  No
- Consumed vitamins or supplements:  Yes  No

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date