CORNERSTONE
FAMILY CHIROPRACTIC

Patient Intake Form

Patient Information

Name_____ Date _____

Address_____ City_____ State_____Zip_____

Home Phone_____Cell Phone_____ Email _____

Date of Birth_____ Age___ Occupation_____ Employer/School_____ Height ____ Weight ____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated Gender □M □F

Spouse's Name_____ Spouse's Employer _____ Spouse's Occupation _____

Have you ever received Chiropractic Care? □ Yes □ No / If Yes, when was your last adjustment? _____

Who may we thank for referring you? _____

How can we help you?

What brings you in today? _____

_____

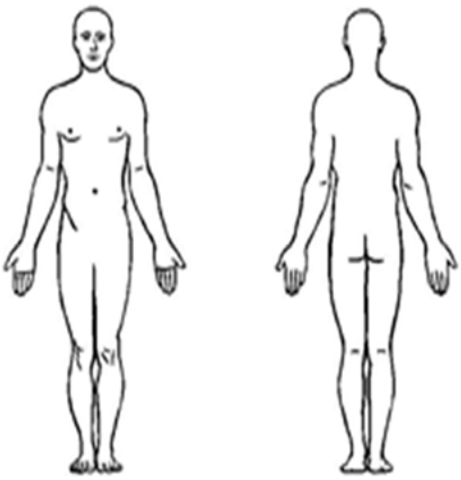
If you are already experiencing a symptom(s), what is it? _____

When did your symptom(s) appear? _____

How severe are your symptoms? (Circle) **0 1 2 3 4 5 6 7 8 9 10**

(Mild symptoms) (Intense Symptoms)

Please circle areas on the image to the right where you have discomfort or other symptoms:



How does it feel?

□ Sharp □ Dull □ Throbbing □ Comes and Goes

□ Shooting □ Burning □ Stiffness □ Constant

□ Numbness □ Aching □Worse in evening □ Tingling

□ Worse in morning □Other _____

Activities or movements that are painful to perform:

□Sitting □Standing □Walking □Bending

□Transitioning from sit to stand □Other _____

Does the pain travel in your body? □Yes □No If Yes, where? _____

Is there anything that makes this problem worse? _____

Have you done anything that gives you relief? _____

Other health care providers you have seen for this condition_____

Impact of Symptoms

How is this symptom/condition interfering with your life? (Check all that apply)

□ Work □ Sleep □ Energy □ Relationships

□ Exercise □ Recreation □ Attitude □ Productivity

□Daily Routine □Other _____

Health History

Please check the box beside any condition that you have or have had in the past:

□ AIDS/HIV
□ Alcoholism
□ Fatigue
□ Jaw pain/TMJ issues
□ Loss of memory
□ Asthma
□ Back pain
□ Heart Issues
□ Cancer
□ Circulation issues
□ Childhood illness
□ Osteoporosis
□ Blood in stool
□ Anxiety
□ Menstrual issues
□ Chest pain
□ Sinus issues
□ Fibromyalgia
□ Loss of sex drive
□ Sleep problems
□ Recent bowel/bladder changes
□ Depression
□ Gout
□ Stroke
□ Hepatitis
□ Ankle swelling
□ Immune issues
□ Lymphatic issues
□ Neck pain
□ Ringing in ears
□ Shortness of breath
□ Chronic cough
□ ADD/ADHD
□ Yeast infections
□ Arteriosclerosis
□ Arthritis
□ Sciatica
□ High blood pressure
□ Menopause
□ Impotence
□ Plantar Fasciitis
□ Diabetes
□ Digestive issues (Constipation/Diarrhea/IBS)
□ Shoulder/Elbow/Wrist/Hand issues
□ Headaches/Migraines
□ Hormone imbalance (Thyroid, etc.)
□ Hip/Knee/Ankle/Foot issues
□ Multiple sclerosis
□ Reproductive issues
□ Scoliosis
□ Dizziness/Loss of balance/Vertigo
□ Urinary issues (overactive bladder / other: _____)
□ Coughing up blood
□ Abnormal blood pressure
□ Losing weight without trying
□ Pain that wakes you up at night
□ Heart burn/acid reflux/GERD
□ Allergies: Circle one: seasonal / food / other
□ Parkinson's
□ Overweight
□ Loss of smell, taste, hearing, sight
□ Other_____

Injuries/Surgeries (Please provide date)

List all past motor vehicle accidents_____

List any injuries / traumas (as child or adult) _____

Broken bones / dislocations _____

List all past surgeries _____

Children & Pregnancy

How many children do you have? _____ Are you currently pregnant? □ No □ Yes, I am due _____

Children's ages_____ Health concerns regarding this pregnancy_____

Children's health concerns _____ Number of past pregnancies _____

Stress Test

Physical Stress: **Check box applicable (past or present):**

- Birth traumas (as a mother or child) ☐
- Sitting on a wallet for years ☐
- Sleeping position – stomach ☐
- Extensive computer work ☐
- Carrying heavy purse/backpack/child ☐
- Repetitive lifting/bending ☐
- Continuous hours sitting/standing ☐
- Minimal/no exercise ☐

Chemical Stress

- Environment (i.e. pollution) ☐
- Smoker ☐
- Second hand smoke ☐
- Poor diet ☐
- Excessive caffeine ☐
- Excessive sugar ☐
- Artificial sweeteners ☐
- Prescription drugs ☐
- Over-the-counter drugs(i.e. Tylenol, Motrin)☐

Emotional Stress

- Relationships ☐
- Career ☐
- Children ☐
- Suppressed feelings ☐
- Sickness or loss of loved one ☐

Which do you feel is your primary stress? ☐ **Physical** ☐**Chemical** ☐**Emotional**

Please Explain: _____

_____

Allergies, Medications, Supplements

ALLERGIES	MEDICATIONS (and reason for taking them)	SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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