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Chiropractic Intake

First Name _____ Middle Initial ___ Last Name _____

Address_____ Home Phone _____ Cell Phone _____

City _____ State ___ Zip _____ Sex: M ___ F ___ O ___ Birth date _____

Email _____ Status: Single ___ Married ___ Widowed ___

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____

Insurance: Y N Carrier: _____ Policy #: _____

Policy Holder: _____ Relationship to you: _____ Their B/D _____

Emergency Contact: _____ Relationship _____ Phone _____

Is your visit today related to an accident? ☐ Yes ☐ No

If yes: ☐ Auto Accident ☐ Sports Related ☐ Work Related ☐ Other

If accident related: Date of Injury: _____

What health problem brought you to us today? _____

This problem is ☐ Worsening ☐ Staying the Same ☐ Improving

Global Health Scale: Rate your general well-being

Poor 0 _____5_____10 Good

Demographics

How tall are you: _____ How much do you weigh? _____

Do you know what your blood pressure runs? _____

Do you have a dominant hand? Please circle: Right Left Ambidextrous

Do you consider yourself part of a race or ethnic group? Yes No

If yes, what race/group? _____

Who is your primary care physician? _____ When was your last physical? _____

Allergies

Are you allergic to any medications? List allergies to medication (and your reaction to them):

☐ I have no known allergies.
☐ I am allergic to: _____. My reaction is: _____

_____ _____
_____ _____
_____ _____

☐ Additional allergies listed on back

Sleep

Healing occurs when you are asleep, and sleep is essential for proper immune system function. The following questions are about your sleep patterns:

How many hours do you sleep [of 24]? _____
How much additional time do you lay in bed attempting to sleep [of 24]? _____

Please rate the quality of your sleep:

I wake up as tired as when I went to bed = 0 I wake up refreshed and ready to go = 10
0 _____5_____10

Do you wake up during the night? Y N If yes, how many times, on average? _____
If you wake up, is it generally at a particular time, no matter when you go to sleep? Y N
If yes, what time(s) do you wake up? _____

Trauma

Trauma may include bad falls, broken bones, blows to the head, injuries at work and auto accidents. Please describe any traumatic incidents and give us either the year or your age when the trauma occurred, to the best of your memory. If you need more room, please check the box and continue on the back of this page.

Incident **Year/Age**

1._____
2._____
3._____

☐ Additional traumas listed on back

_____
Print Name

Surgeries

One common trauma that we often overlook is from elective or emergency surgery. The scar tissue that results may cause or contribute to many of our structural problems.

Please list any surgery you have had, what it was for, and either the year or your age when the surgery happened. If you need more room, please check the box and continue on the back of this page.

Surgery	Reason	Year/Age
1.		
2.		

☐ Additional surgeries listed on back

Chronic Health Issues

If you have a chronic health problem (examples: diabetes, osteoporosis, emphysema, asthma, rheumatoid arthritis, fibromyalgia, high blood pressure, etc.) please detail them below:

_____

_____

☐ Additional chronic health issues listed on back

Medications AND Supplements

Please list:

- The medications and other herbal and nutritional supports you are currently taking.
- The condition for which you are taking it, the dosage and frequency.
- If prescribed 'as needed', estimate the amount taken per week, month or year.

Medications/Supplement	Taken For	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			

☐ Additional medication/supplements listed on back

_____
Print Name

Water:

I drink _____ (#) _____ (ounce) cups/glasses of water per day.

- ☐ I drink water directly from my tap. ☐ I have softened water in my home.
- ☐ I treat tap water at home before I drink it by
  - ☐ A filter ☐ pitcher ☐ on my faucet ☐ in my refrigerator door ☐ multistage
- ☐ I drink bottled water I purchase
  - ☐ in single serving soft plastic bottles ☐ in 5-gallon hard plastic bottles.

Tobacco:

- ☐ Never used tobacco in any form
- ☐ I stopped using tobacco [Choose one:]
  - _____ years ago
  - In the year _____
- ☐ I use some form of tobacco every day.

Family Health History	**First Name**	**Year of birth [if known]**	**Serious illnesses or other medical conditions and age at onset [if known]**	**If deceased list cause and age at death [if known]**
Mother				
Father				
sibling				
sibling				

_____ Today's Date

_____ Patient's Printed Name

_____ Patient's Signature (over 17 years old)

_____ Guardian Signature (under 18 years old)

_____ Guardian Printed Name

_____ Print Name