Intake History

Today's Date:____________

Name ______________________________ DOB____/___/_____ SS#____-____-_______

Address______________________ City__________________ State_____ Zip_________

Phone H____________ W _____________Cell________________ E-mail Address__________________

Marital Status M S W D

Emergency Contact______________________ Relation____________ Phone ______________

Occupation ______________________ Employer ___________________ Hgt______ Wgt_______

Referred by_____________________ Is this a work related injury/auto accident? Y N

Name of Spouse / Guardian __________________ Names/Ages of Children______________________

Chief Complaint____

Name of Primary Care Physician____

Please use the diagram if you have pain. **Cause of this condition?_______________________**

List other doctors hospitals seen for this condition

____

Do you have any allergies to medications?

____

Do you have any other health problems/concerns?

____

List any medications you are taking _______________

____

⌘⌘⌘

List any accidents, bad falls (including childhood), significant illnesses, operations, injuries/physical traumas you have had and include dates if possible:

____

____

Have you ever been under chiropractic care before Y N For what problem? _______________________________

Have you had x-rays in the past 12 months Y N If yes, reason? _____________

Women, are you or do you think you might be pregnant? Y N Date of LMP ____________

Do you use a heel lift/orthotic/arch support? Y N

OVER

Past / Present

- ☐ ☐ Neck pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Pain in upper arm
- ☐ ☐ Hand pain
- ☐ ☐ Wrist pain
- ☐ ☐ Upper back pain
- ☐ ☐ Low back pain
- ☐ ☐ Pain in upper leg or hip
- ☐ ☐ Pain in lower leg or knee
- ☐ ☐ Pain in ankle or foot
- ☐ ☐ Jaw pain
- ☐ ☐ Fainting
- ☐ ☐ Visual disturbances
- ☐ ☐ Seizures
- ☐ ☐ Dizziness
- ☐ ☐ Headache
- ☐ ☐ Muscular Incoordination
- ☐ ☐ Ringing in the ear
- ☐ ☐ Rapid heart rate
- ☐ ☐ Chest pain
- ☐ ☐ Loss of appetite
- ☐ ☐ Anorexia
- ☐ ☐ Abnormal weight gain/loss
- ☐ ☐ Excessive thirst
- ☐ ☐ Chronic cough
- ☐ ☐ Chronic sinusitis
- ☐ ☐ General fatigue
- ☐ ☐ Irregular menstrual flow
- ☐ ☐ Breast soreness/lumps
- ☐ ☐ Endometriosis
- ☐ ☐ PMS
- ☐ ☐ Incontinence
- ☐ ☐ Painful or frequent urination
- ☐ ☐ Abdominal pain
- ☐ ☐ Constipation/irregular bowels
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Heartburn/ GERD/Indigestion
- ☐ ☐ Rash/Hives
- ☐ ☐ Depression

Past / Present

- ☐ ☐ Aortic Aneurysm
- ☐ ☐ High blood pressure
- ☐ ☐ Angina
- ☐ ☐ Heart attack
- ☐ ☐ Stroke
- ☐ ☐ Asthma
- ☐ ☐ Cancer
- ☐ ☐ Tumors
- ☐ ☐ Prostate problems
- ☐ ☐ Blood disorders
- ☐ ☐ Arthritis/ Rheumatoid arthritis
- ☐ ☐ Diabetes
- ☐ ☐ Ulcers
- ☐ ☐ Liver/Gallbladder problems
- ☐ ☐ Kidney stones
- ☐ ☐ Hepatitis
- ☐ ☐ Bladder infections
- ☐ ☐ Colitis
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ HIV/AIDS
- ☐ ☐ Systemic Lupus

If a family member has had any of the following, please mark in the appropriate box:

- ☐ Cancer
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Heart problems
- ☐ Lung problems
- ☐ Other ________________
- ☐ Epilepsy
- ☐ Chronic back problems
- ☐ Chronic headaches
- ☐ Lupus
- ☐ High blood pressure

Do you have a permanent disability rating? Y N

Date rating received _________ Rating Percentage ______%

Check all that apply

Past / Present

- ☐ ☐ Tobacco
- ☐ ☐ Alcohol
- ☐ ☐ Drug/alcohol dependence
- ☐ ☐ Caffeinated soft drinks/coffee/tea

 # cups/day _____

(If applicable) **Name of insurance carrier ____**

ID # ________________________________