Patient Health History - Intake Form

(PLEASE PRINT)

Patient's Personal Info

Patient's Full Name: ______________________ Date of Birth: __________ Age: _____ Gender: ☐ M or ☐ F

Patient/Guardian Signature: ______________________ Today's Date: ______________

Parent/Legal Guardian Name (if applicable): ______________________

Billing Address: ______________________

Home Phone: ______________ Mobile Phone: ______________ Email: ______________

Marital Status: ☐ Single ☐ Married ☐ Other| Spouse Name and Phone #: ______________

Employment Status

☐ - Employed ☐ - Retired ☐ - Unemployed ☐ - Student ☐ - Other

Employer: ______________________ Occupation: ______________________

Prior Care

Have you consulted a chiropractor before? ☐ Yes ☐ No

If so, what is the name of the chiropractor you saw? ______________________

Primary Care Physician: ______________________

Main Complaint: REQUIRED

Main area of pain today:______________________ Intensity 0-10: ________

Pain radiates/spreads into:______________________

Please check the following symptoms that you are feeling:

☐ - Dull ☐ - Sharp ☐ - Throbbing ☐ - Burning ☐ - Deep ☐ - Aching ☐ - Tingling ☐ - Stabbing

☐ - Cramping ☐ - Numbness ☐ - Radiating ☐ - Stiffness ☐ - Weakness ☐ - Other: ______________

Please circle how frequently you are feeling these symptoms: Daily/Weekly/Monthly

0% ------------------------- 25% ------------------------- 50% ------------------------- 75% ------------------------- 100%

How did your problem begin? ______________________

Approximant Onset Date: ______________

Condition is aggravated by:______________________

Condition is relieved by:______________________

Day/time when your pain is worse or better? ______________________

Anything else we should know about your current condition? ______________________

____

Additional Complaints:______________________ Intensity 0-10: ____________

Personal Medical History

Current Illnesses:

____

Previous Illnesses:

____

Previous Injuries:

____

Surgeries:

____

Reason(s) for surgeries:

____

Pregnancies (if applicable - please put year(s) pregnant during the last 18 years e.g. 2016, 2019):

____

Medications & Nutritional Supplements

Current medications and nutritional supplements, including frequency and dosage *if known*.

If there are no current medications or supplements, check here: ☐

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

______________________________ Start Date: __________

Allergies

List any known allergies you have:____

If no allergies are known, check here: ☐

Smoking Status

Do you currently smoke tobacco of any kind? ☐ - Smoker ☐ - Former Smoker ☐ - Never been a smoker

Review of Body Systems

A full review of the systems of the body helps us get a full picture of your health. Please let us know if you have any of the issues below or specify that you don't have any complaints in those areas of your body.

Musculoskeletal

Condition	Have	Had	No
Osteoporosis			
Arthritis			
Scoliosis			
Neck Pain			
Back Problems			
Hip Disorders			
Knee Injuries			
Foot/Ankle Pain			
Shoulder Problems			
Elbow/Wrist Pain			
TMJ Issues			
Poor Posture			

Neurological

Condition	Have	Had	No
Anxiety			
Depression			
Headache			
Dizziness			
Pins and Needles			
Numbness			

Cardiovascular

Condition	Have	Had	No
High Blood Pressure			
Low Blood Pressure			
High Cholesterol			
Poor Circulation			
Angina			
Excessive Bruising			

Respiratory

Condition	Have	Had	No
Asthma			
Apnea			
Emphysema			
Hay Fever			
Shortness of Breath			
Pneumonia			

Integumentary

Condition	Have	Had	No
Skin Cancer			
Psoriasis			
Eczema			
Acne			
Hair Loss			
Rash			

Digestive

Condition	Have	Had	No
Anorexia/Bulimia			
Ulcer			
Food Sensitivities			
Heartburn			
Constipation			
Diarrhea			

Endocrine

Condition	Have	Had	No
Thyroid Issues			
Immune Disorders			
Hypoglycemia			
Frequent Infection			
Swollen Glands			
Low Energy			

Sensory

Condition	Have	Had	No
Blurred Vision			
Ringing in Ears			
Hearing Loss			
Chronic Ear Infection			
Loss of Smell			
Loss of Taste			

Genitourinary

Condition	Have	Had	No
Kidney Stones			
Infertility			
Bed Wetting			
Prostate Issues			
Erectile Dysfunction			
PMS Symptoms			

Constitutional

Condition	Have	Had	No
Fainting			
Low Libido			
Poor Appetite			
Fatigue			
Sudden Weight Gain/Loss			
Weakness			

End of Form Acknowledgement

Please check boxes for your consent

General Verification

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. ☐

Permission to Contact

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. ☐

How did you hear about us?

____

Who referred you?

____