NAME: ___________________________ **DATE:** _______________

Patient Intake Form

Are your present problems due to an injury? ❑Yes ❑N Enter the date of the injury: ___________________________

Was the injury? ❑Auto Accident ❑Personal Injury ❑Other: ____

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _______________

List symptoms experienced immediately after the injury: ____

Do you have any current work restrictions due to this condition?□Yes □No

List symptoms you are experiencing today: ____

Choose the severity level associated with each symptom □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Severe

HABITS

❑ Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol ❑Coffee/Caffeine

❑Water Daily ❑Exercise

FAMILY HISTORY

	Diabetes	Cancer	Back Pain
Mother	□	□	□
Father	□	□	□

Are you taking any medication (prescription or over-the-counter)? ***❑Yes*** ***❑No***

If Yes, please indicate the following:

Medication: ____________________________
Route: Oral Intravenous
Frequency: ___________________
Began Use: ___________________

Medication: ____________________________
Route: Oral Intravenous
Frequency: ___________________
Began Use: ___________________

Medication: ____________________________
Route: Oral Intravenous
Frequency: ________________
Began Use: ________________

Medication: ____________________________
Route: Oral Intravenous
Frequency: ________________
Began Use: ________________

Do you have allergies to medication? ***❑Yes*** ***❑No*** ***If Yes, please indicate the following:***

Allergy: ______________ Reaction: _______________ *Allergy*: ______________ Reaction: ________________

Have you ever had any surgeries? ***❑Yes*** ***❑No*** **(If yes, please enter the approximate date of surgery.)**

DATE		DATE		DATE	
________________	Back Operation	________________	Hernia	________________	Gall Bladder
________________	Female Organs	________________	Thyroid	________________	Stomach

Other ____

CHIROPRACTIC/MEDICAL HISTORY & DATA

PRIOR CHIRO CARE: YES ___ NO___ LAST ADJUSTMENT: _________

TREATED BY: CHIROPRACTOR YES __ NO __ PRIOR CHIROPRACTOR: ______________

PCP NAME: ____________________________

******PLEASE COMPLETE THE BACKSIDE OF THIS INTAKE FORM******

OPERATIONS AND PROCEDURES

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ ________________
- ❑ Bronchitis
- ❑ Chills
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Night Sweats
- ❑ Numbness or Pain (arms,hands,Legs)

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

NOSE/EAR/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent or painful Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Hernia
- ❑ Pain Between shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Back Pain

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid/Slow Heart

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis ❑Anemia ❑Heart Disease ❑Arthritis ❑Measles ❑Epilepsy

❑Rheumatic Fever ❑Mumps ❑Mental Disorder ❑Polio ❑Chicken Pox ❑Pleurisy

❑Tuberculosis ❑Diabetes ❑Cancer ❑Venereal Disease ❑HIV Positive

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I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

****Patient's/Guardian's Signature: ____ Date: ________________________**