CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____ (LAST NAME)

_____ (FIRST NAME) (MIDDLE INITIAL)

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

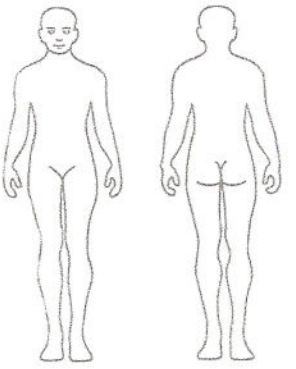
_____

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

How bad is it? How intense are your symptoms? (circle)

0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

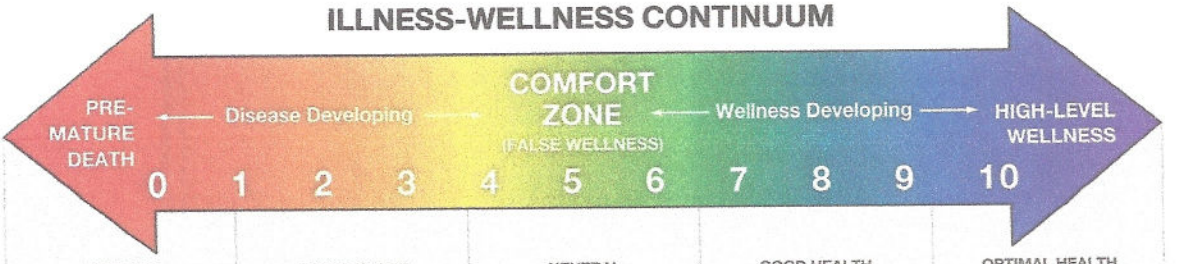
	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 (NOT COMMITTED) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

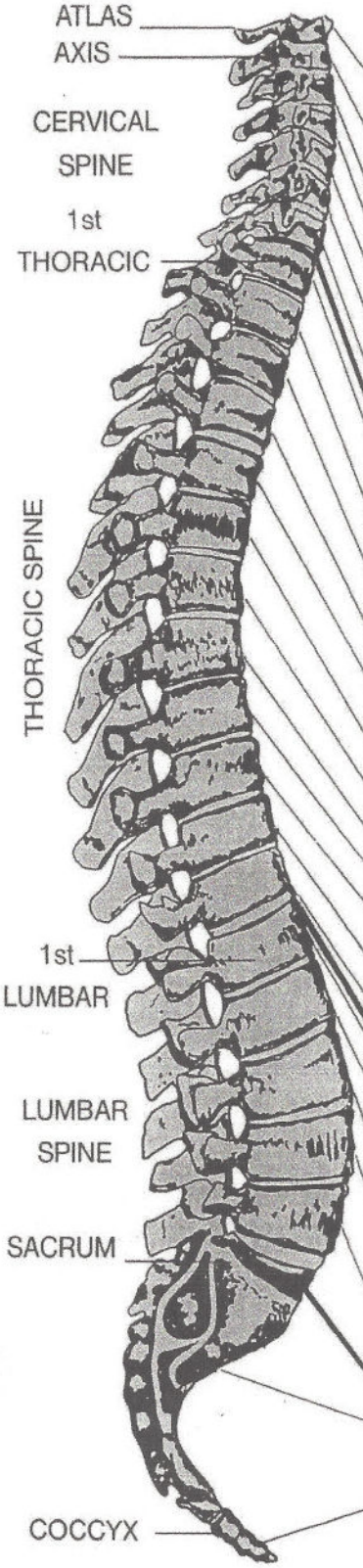
ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy*, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

Please Check Below



Vertebrae	Areas Controlled by Nerves*		Possible Effects of a Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	NECK REGION	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.		☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.		☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.
4C	Nose, lips, mouth, eustachian tube.		☐hay fever,☐runny nose,☐hearing loss,☐adenoids.
5C	Vocal cords, neck glands, pharynx.		☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.
6C	Neck muscles, shoulders, tonsils.		☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.
7C	Thyroid gland, bursae in the shoulders, elbows.		☐ bursitis, ☐ colds, ☐ thyroid conditions.
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.		☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.
2T	Heart, including its valves and covering; coronary arteries.		☐ functional heart conditions and certain chest conditions.
3T	Lungs, bronchial tubes, pleura, chest, breast.		☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.
4T	Gall bladder, common duct.	MID-BACK	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.
5T	Liver, solar plexus, circulation (general).		☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.
6T	Stomach.		☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.
7T	Pancreas, duodenum.		☐ ulcers, ☐ gastritis.
8T	Spleen.		☐ lowered resistance.
9T	Adrenal and supra-renal glands.		☐ allergies, ☐ hives.
10T	Kidneys.		☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.
11T	Kidneys, ureters.		☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.
12T	Small intestines, lymph circulation.		☐rheumatism,☐gas pains, ☐certain types of sterility.
1L	Large intestines, inguinal rings.	LOW BACK	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.
2L	Appendix, abdomen, upper leg.		☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.
3L	Sex organs, uterus, bladder, knees.		☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.
4L	Prostate gland, muscles of the lower back, sciatic nerve.		☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.
5L	Lower legs, ankles, feet.		☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.
SACRUM	Hip bones, buttocks.	PELVIS	☐ sacro-iliac conditions, ☐ spinal curvatures.
COCCYX	Rectum, anus.		☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

Our Privacy Policy

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your information to:

* Treat you, Collect payment, Run our office, Do research, Inform you about other services, Discuss your case with family, Include you in care classes, Thank you for referring other patients.

We may use your health information for:

Health and safety reasons, Reporting to law officials, Reporting victims of abuse, Court hearings and filings, Reporting to worker's compensation.

You have the right to:

Request a copy of your health record, Request a list of whom we share your information, Ask us to limit the information we share, Advise our management if you believe your privacy rights have been violated, Request confidential communications, Amend your protected health information.

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs;

I, _____ have read and fully understand the above statements and consent to an examination and accept chiropractic care.

(print name)

_____ _____

(signature) (date)

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CHIROPRACTIC