

**PATIENT INTAKE FORM**



Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

\_\_\_\_\_ Today's Date: \_\_\_\_\_  
City State Zip

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ Carrier: \_\_\_\_\_

Appointment Reminder: Email  Text  Appointment Card

Relationship status: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Relationship Phone #

Occupation: \_\_\_\_\_ Years at this job: \_\_\_\_\_

Have you ever been adjusted by a Chiropractor? Yes  No

If yes, what was the reason for the visit? \_\_\_\_\_

Who can we thank for sending you to us? \_\_\_\_\_

**Describe Reason for Today's Visit:** \_\_\_\_\_

When did you first notice it? \_\_\_\_\_ What caused it? \_\_\_\_\_

How is the condition now? Better  Worse  Same  Comes and goes

When does it occur? \_\_\_\_\_ How often? \_\_\_\_\_

How long does it last? \_\_\_\_\_ Does it travel? \_\_\_\_\_

What makes it worse?

What makes it better?

- Driving
- Walking
- Sitting
- Bending
- Standing
- Bowel Movement

- Breathing
- Coughing
- Sleeping
- Working
- Exercising
- Other \_\_\_\_\_

- Chiropractic
- Rest
- Lying Down
- Sitting
- Standing
- Walking
- Ice

- Heat
- Stretching
- Massage
- Medication
- Nothing
- Other \_\_\_\_\_

Rate your pain TODAY: 1  2  3  4  5  6  7  8  9  10   
 (best) (worst)

Rate your AVERAGE pain: 1  2  3  4  5  6  7  8  9  10   
 (best) (worst)

My condition interferes with: Work  Sleep  Daily Routine  Other Activities

Describe: \_\_\_\_\_

Have you had this condition before? Yes  No  When? \_\_\_\_\_

Have you seen another doctor for this? Yes  No  When? \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Were x-rays or other imaging studies performed? \_\_\_\_\_

Type of Treatment/ Results: \_\_\_\_\_

Health Habits & Lifestyle

Do you exercise? Yes  No

If yes, what type and how often? \_\_\_\_\_

What activities/sports do you participate in? \_\_\_\_\_

What position(s) do you sleep in? Back  Right Side  Left Side  Stomach

Hours per night? \_\_\_\_\_ Quality? Good  Fair  Poor  Interruptions per night? \_\_\_\_\_

Personal Health History

List any medications and why you are taking each one (including over-the-counter)

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Have you ever had any surgeries or been hospitalized?    Yes     No

When and for what? \_\_\_\_\_

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Please list all accidents and injuries you've had, including childhood: (include dates) \_\_\_\_\_

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Goals of Care (choose all that apply)

- Relief of pain: Removing symptoms of pain and discomfort
- Corrective Care: correcting/relieving the cause of the problems as well as the symptoms
- Comprehensive care: bringing your body to optimal health

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits. Chiropractic care is an important addition to a healthier lifestyle but requires TIME to allow your body to heal.

***\*\*We ask that you commit to 12 visits in order to maximize your response to the care received in this office\*\****

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

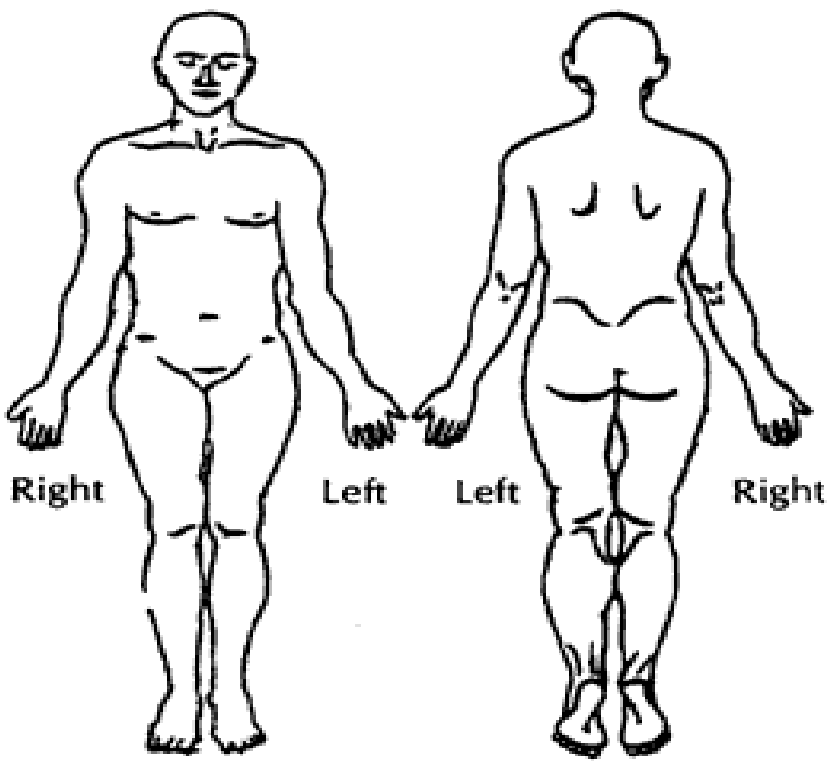
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Name (if minor patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

Guardian's Signature (if minor patient): \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_



**PAIN DIAGRAM**

Please mark the location(s) of your pain using the following symbols:

- N = numbness/tingling
- ^ = sharp/stabbing
- B = burning
- S = shooting/travelling
- A = aching
- O = other (describe)
- T = tightness

Additional information regarding pain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor Signature

Date