

Chiropractic Intake

Name _____ S.S.N. _____ Date _____

Address _____ City/State _____ ZIP _____

D.O.B _____ Height/Weight _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Cell Phone _____ Email address _____

Spouse/Partner Name _____

Emergency Contact Name _____ ER Contact Phone # _____

Whom may we thank for referring you to us _____

Symptoms developed from: Work Injury ____ Auto Accident ____ Other _____

Have you ever had similar symptoms? (dates) _____

Have you ever had pain in other areas of your spine? (dates) _____

Dates of previous auto accidents _____

List surgical operations w/ dates _____

List any medications you are on _____

Other doctors consulted for this condition? (dates) _____

Do you have a past history of injuries involving: (dates) ankles _____ knees _____

hips _____ wrists _____ elbows _____ shoulders _____

Have you had X-Rays taken of your spine in the last 7 years? _____

Dates of last physical exam _____ Any unusual findings _____

Do you exercise regularly? _____ Types and How often? _____

Do you smoke/use tobacco? _____ If so, how often? _____

Do you drink alcohol? _____ If so, how often? _____

Men: Date of last prostate exam _____ Date of last colon exam _____

Any unusual Findings _____

Women: Date of last pap smear _____ Date of last mammogram _____

Any unusual findings _____

Are you pregnant? _____ Due Date _____ Trying to get pregnant? _____

Do you have children? _____ How many? _____

Do you have breast implants? _____ Taking Birth Control? _____

Family History: (List any significant diseases, i.e.: diabetes, cancer, etc.) Are you adopted? _____

Mother _____ Father _____

Grandparents _____ Aunt/Uncle/Siblings _____

Chief Complaint _____

ONSET (what were you doing when injury occurred) _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other _____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other _____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

Complaint #2 _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other _____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other _____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

- _____ Headache
- _____ Allergies
- _____ Dizziness
- _____ Deafness
- _____ Ringing in Ears
- _____ Loss of Balance

- _____ Fainting
- _____ Eye Pain
- _____ Failing Vision
- _____ Nosebleeds
- _____ Sinus Infection
- _____ Blackouts

CHEST

- _____ Chest Pain
- _____ Difficulty Breathing
- _____ Asthma

OTHER

- _____ Loss of Sleep
- _____ Nervousness
- _____ Depression
- _____ Fever

ABDOMEN

- | | |
|--|---|
| <input type="checkbox"/> Difficult Digestion | <input type="checkbox"/> HIV+/Aids |
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Change in Menstrual Cycle |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Change in Urinary Function | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Change in Bowel Function | <input type="checkbox"/> Other _____ |

PLEASE CHECK ANY OF THE FOLLOWING YOU'VE HAD

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Stone/ |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Malaria | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Ulcers |

Signature _____ **Date** _____

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

Do **not** want a copy Received a copy

Printed Name: _____

Signature _____

Date _____