## **CHIROPRACTIC INTAKE & HISTORY**



PATIENT	INFORI	MATION	I .						
Patient Name					_ Employer /	School			
		LAST N	AME		Occupation	n			
Address	FIRST NAME		MIDDLE	INITIAL		Name			
City		9	State Zi	)		Employer			
Home Phone						Occupation			
Cell Phone	70		Provider			OF EMERGENCY, C			
Email									
Sex □ M I	⊒ F Age		Birthday	<u> </u>	_ Relationshi	ip			
■ Married	□ Widow	red 🗖	Single	Minor	Contact Nu	umber			
☐ Separated	☐ Divorc	ed 🗖	Partnered		Who may	we thank for referr	ing you?		
HOW CA What brings yo									
f you are alrea	dy experiencia	na a symptor							
i you are allead	иу ехрепенсы	ig a symptor	ii, what is it?						
How bad is it?	How intense a	are your sym	ptoms? (circle	e) NO SYMPTO	<b>0 2 €</b> ms	9 9 9	6 6	8 9	INTENSE SYMPTOMS
Please circle ar	eas to the rig	nt where you	have pain or	other sympt	toms:	المن المن المن المن المن المن المن المن	3 &		
What does it fe	eel like? (ched	k where app	oropriate)			$\int_{\Lambda}$	$\int_{\Lambda}$		
Numbness		Sharp							
☐ Tingling		Shooting				(S/ Y/S)	(S) X)		
☐ Stiffness		Burning				0/ 1/0	0	0	
Dull		Throbbing				\ \ (	\ )\ /		
						( () \	( \)		
☐ Aching		Stabbing				\ /\ /	\ /\ /		
☐ Cramping		Swelling				) \ / (	) \		
☐ Nagging		Other		-					
IMPACT	OF YOU	R SYMI	PTOMS						
				fe? (check w	/here appropriate)				
,	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Seve Effec
Work					Energy				
Exercise					Attitude				
Recreation					Patience				
Relationships					Productivity				
Sleep					Creativity	0			
Self-Care					Other				
How committee	d are you to c	orrecting this	s issue?	0 0	2 8	4 6 6	0	8 9	•

	IL	LNESS	-WELL	NESS (	ON	TINU	UM			
			COL	MFORT						
PRE-	Disease Deve	eloping —		ONE	_	Wellne	ss Devel	oping —	→ HIG	H-LEVEL
MATURE DEATH				WELLNES						ELLNESS
0	1 2	3	4	5		7	8	9	10	
						300				
DISEASE Multiple medications		HEALTH ptoms	No	EUTRAL symptoms		Rec	OD HEALT Jular exercis	se		IAL HEALTH % function
Poor quality of life Potential becomes limited	Sur	therapy rgery	Exerc	on inconsisten cise sporadic		Wellr	ood nutrition less educat	ion	Active	us development participation
Body has limited function	Losing nor	mal function		ot a high prior	У		nerve interf			ess lifestyle
n the arrow diagram abo	we.									
			0							
A. What number do you										
3. In what direction is yo		tly headed? _								
nat are your health goals										
IMMEDIATE										
SHORT TERM										
LONG TERM _										
				Are y	ou curi	rently pre	egnant?	□ No	☐ Yes, I a	m due
CHILDREN & Plow many children do you hildrens' ages?	u have?			Num	oer of p	past preg	nancies?		•	
ow many children do you	u have?			Num	oer of p	past preg	nancies?		•	
ow many children do you nildrens' ages? nildrens' health concerns	u have?s?			Num Heal	oer of p	past preg	nancies? arding this	s pregnanc	;y?	
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