CHIROPRACTIC INTAKE & HISTORY

SHAFT CHIROPRACTIC

PATIENT INFORMATION

Last Name _____
First Name _____ Middle Initial ____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Social Security Number _____
Birthdate _____
Sex ☐M ☐F
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Employer/School _____
Occupation _____
Spouse's Full Name _____
Spouse's Employer _____
Spouse's Cell _____
Spouse's Date of Birth _____

IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact Number _____

Who may we thank for referring you?
_____

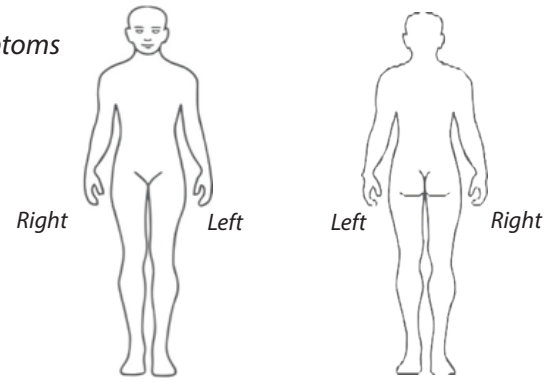
Primary Care Physician: Name _____ Phone _____

HOW CAN WE HELP YOU?

What brings you in today? _____
_____
When did your symptom first appear? _____
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS *INTENSE SYMPTOMS*

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



What does it feel like? (circle any that apply)

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

Did a Motor Vehicle Accident, Workers Comp or Sports Related Injury cause this? ☐ Yes ☐ No

How committed are you to correcting this issue? 1 2 3 4 5 6 7 8 9 10
NOT COMMITTED *VERY COMMITTED*

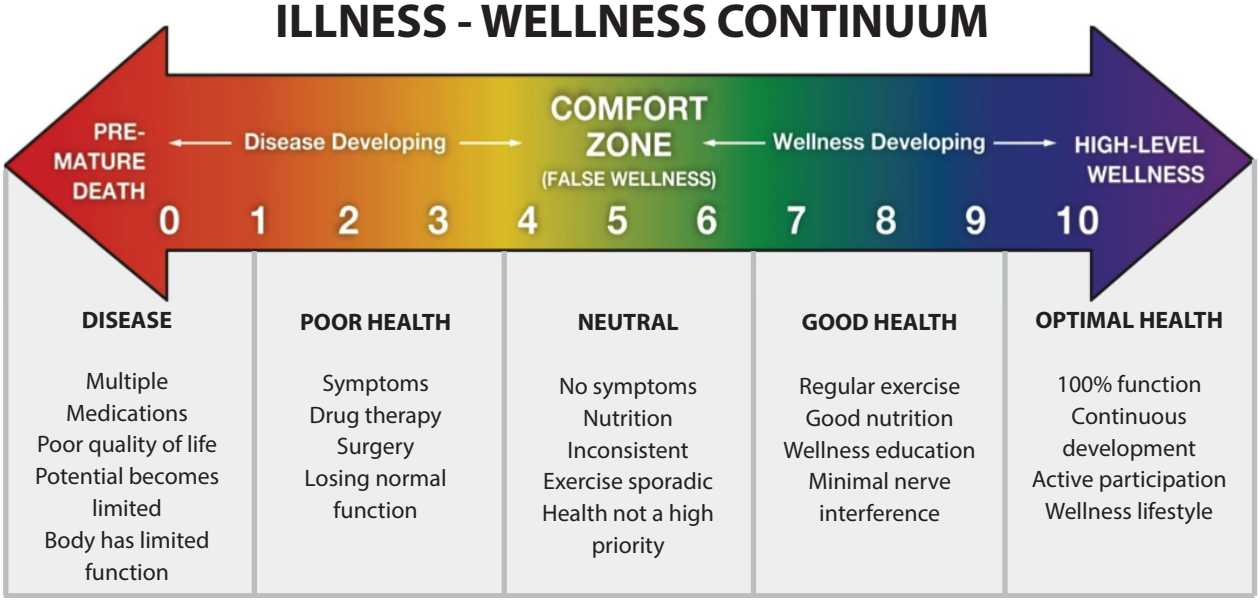
IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (circle all that apply)

	No Effect				Severe Effect		No Effect				Severe Effect
Work	1	2	3	4	5	Energy	1	2	3	4	5
Exercise	1	2	3	4	5	Attitude	1	2	3	4	5
Recreation	1	2	3	4	5	Patience	1	2	3	4	5
Relationships	1	2	3	4	5	Productivity	1	2	3	4	5
Sleep	1	2	3	4	5	Creativity	1	2	3	4	5
Self-Care	1	2	3	4	5	Other_____	1	2	3	4	5

PATIENT WELLNESS ASSESSMENT

ILLNESS - WELLNESS CONTINUUM



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

Children's ages? _____ Number of past pregnancies? _____

Children's health concerns? _____

Health concerns regarding this pregnancy? _____

FAMILY HISTORY

	Mother	Father	Sibling	Child	Unknown
Back Pain:	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐
Arthritis:	☐	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐
Thyroid:	☐	☐	☐	☐	☐
Good Health:	☐	☐	☐	☐	☐

SOCIAL HISTORY

	Daily	3x/week	2x/week	1x/week	2x/month	1x/month	never
Standing:	☐	☐	☐	☐	☐	☐	☐
Sit at a Desk:	☐	☐	☐	☐	☐	☐	☐
Work on a Computer:	☐	☐	☐	☐	☐	☐	☐
Work/Text on a Phone:	☐	☐	☐	☐	☐	☐	☐
Moderate/Heavy Labor:	☐	☐	☐	☐	☐	☐	☐
Stay at Home:	☐	☐	☐	☐	☐	☐	☐
Deliver Packages:	☐	☐	☐	☐	☐	☐	☐
Retired:	☐	☐	☐	☐	☐	☐	☐
Tobacco/Smoke:	☐	☐	☐	☐	☐	☐	☐
Alcoholic Beverages:	☐	☐	☐	☐	☐	☐	☐
Caffeine:	☐	☐	☐	☐	☐	☐	☐
Exercise:	☐	☐	☐	☐	☐	☐	☐

ALLERGIES, MEDICATIONS & SUPPLEMENTS

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

SURGERIES

Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

PRE-EXISTING CONDITIONS

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Alcoholism/Drug Addiction
- ☐ Allergies
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Back pain
- ☐ Blood Clots
- ☐ Blurred Vision
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ Dizziness/Vertigo
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Elbow/Wrist/Hand Issues
- ☐ Fatigue
- ☐ Female Health Problems
- ☐ Fibromyalgia
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Gluten Intolerance
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hip Issues
- ☐ High Blood Pressure
- ☐ Immune Issues
- ☐ Joint Pain
- ☐ Kidney Infections/Stones
- ☐ Menstrual Cramps
- ☐ Mental Disorder
- ☐ Migraines
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Reproductive Issues
- ☐ Reflux/Ulcers
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sexual Dysfunction
- ☐ Shoulder Issues
- ☐ Stress
- ☐ Stroke
- ☐ Suicidal Tendencies
- ☐ TMJ Issues
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Issues
- ☐ Other _____
- ☐ _____
- ☐ _____