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Chiropractic Intake

First Name ______________ Middle Initial ___ Last Name _______________________

Address__________________________ Home Phone __________ Cell Phone __________

City _____________ State ____ Zip ________ Sex M ___ F ___

Email _________________________ May we send your billing to this Email? Yes___No___

Birth date ______________ Single ___ Married ___ Widowed ___

Patient Employed by ________________________ Occupation _______________________

Whom may we thank for referring you? ____

Insurance: Yes___No___ Policy Holder___________________ Relationship ____________

Emergency Contact: ________________ Relationship __________ Phone ______________

Is your visit today related to an accident? ☐ Yes ☐ No

If yes: ☐ Auto Accident ☐ Sports Related ☐ Work Related ☐ Other

If accident related: Date of Injury: _____________________

What health problem brought you to us today? _________________________________

This problem is ☐ Worsening ☐ Staying the Same ☐ Improving

Global Health Scale: Rate your general well-being

Poor 0 __________________________5__________________________10 Good

Demographics

How tall are you: __________________ How much do you weigh? _______________

Do you know what your blood pressure runs? ________________

Do you have a dominant hand? Please circle: Right Left Ambidextrous

Do you consider yourself part of a race or ethnic group? __________

If yes, what race/group? ________________________

Who is your primary care physician? ______________ When was your last physical? ______

Allergies

Are you allergic to any medications? List allergies to medication (and your reaction to them):

☐ I have no known allergies to medication.
☐ I am allergic to: ____________________. My reaction is: ________________________
____________________ ________________________
____________________ ________________________
____________________ ________________________

☐ Additional allergies to medication listed on back

Do you have any other allergies? List your allergies (and your reaction to them):

☐ I have no known allergies.
☐ I am allergic to: ____________________. My reaction is: ________________________
____________________ ________________________
____________________ ________________________
____________________ ________________________

☐ Additional allergies listed on back

Sleep

Healing occurs when you are asleep, and sleep is essential for proper immune system function. The following questions are about your sleep patterns:

How many hours do you sleep each day? _______________
How many hours do you spend in bed each day? ______________

Please rate the quality of your sleep:

I wake up as tired as when I went to bed. I wake up refreshed and ready to go.
0 __________________________________5__________________________________10

Do you wake up during the night? Y N If yes, how many times, on average? _______
If you wake up, is it generally at a particular time, no matter when you go to sleep? Y N
If yes, what time(s) do you wake up? _________________

Name: _____________________________

Trauma

We know that health problems can come from biochemical imbalances due to poor nutrition or toxicity, hormone imbalances from stress or neurological problems from trauma. The average child has at least 1,000 traumas by the age of 13. Please answer the following questions about the traumas you have experienced. These may include bad falls, broken bones, blows to the head, injuries at work and auto accidents.

Please describe any traumatic incidents and give us either the year or your age when the trauma occurred, to the best of your memory. If you need more room, please check the box and continue on the back of this page.

Incident **Year/Age**

1. ______________________________
2. ______________________________
3. ______________________________

☐ Additional traumas listed on back

Surgeries

One common trauma that we often overlook is from elective or emergency surgery. The scar tissue that results may cause or contribute to many of our structural problems.

Please list any surgery you have had, what it was for, and either the year or your age when the surgery happened. If you need more room, please check the box and continue on the back of this page.

Surgery **Reason** **Year/Age**

1. ______________________________
2. ______________________________

☐ Additional surgeries listed on back

Chronic Health Issues

If you have a chronic health problem (examples: diabetes, osteoporosis, emphysema, asthma, rheumatoid arthritis, fibromyalgia, high blood pressure, etc.) please detail them below:

____

____

☐ Additional chronic health issues listed on back

Name: ______________________________

Medications AND Supplements

Medications (prescribed and over the counter) as well as herbal and nutritional supports that are not correct for you can be contributing to the health problems that arise from biochemical imbalances due to poor nutrition or toxicity. Please list:

- The medications and other herbal and nutritional supports you are currently taking.
- The condition for which you are taking it.
- The dosage and frequency. If prescribed 'as needed', estimate and record the amount taken per week, month or year.
- We do need ALL of this information. If you have this information already prepared to hand to doctors, make sure the information is current, make us a copy, give it to us when you turn in this form, and write 'See attached' in the first blank.
- Place a NA in the first blank if you do not take any medications or nutritional supports.

Medications/Supplement	Taken For	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

☐ Additional medication/supplements listed on back

Name: ______________________________

Water:

I drink _______ (#) _________ (ounce) cups/glasses of water per day.

- ☐ I drink water directly from my tap. ☐ I have softened water in my home.
- ☐ I treat tap water at home before I drink it by
  - ☐ A filter ☐ pitcher ☐ on my faucet ☐ in my refrigerator door ☐ multistage
  - ☐ Reverse osmosis
  - ☐ Distilling. ☐ I add minerals to the distilled water that I drink.
- ☐ I drink bottled water I purchase
  - ☐ in single serving soft plastic bottles ☐ in 5 gallon hard plastic bottles.

Tobacco:

Never Used Tobacco:

- ☐ Never used tobacco in any form

Ex-User:

- ☐ Ex-very heavy cigarette smoker (40+/day)
- ☐ Ex-heavy cigarette smoker (20-39/day)
- ☐ Ex-moderate cigarette smoker (10-19/day)
- ☐ Ex-light cigarette smoker (1-9/day)
- ☐ Ex-trivial cigarette smoker (<1/day)
- ☐ Ex-pipe smoker
- ☐ Ex-cigar smoker
- ☐ Ex-user tobacco as chew or snuff

Tobacco User:

- ☐ Chews fine cut tobacco Chews loose leaf tobacco
- ☐ Chews plug tobacco
- ☐ Chews products containing tobacco
- ☐ Chews twist tobacco
- ☐ Snuff user

Smoker:

- ☐ Chain smoker
- ☐ Very heavy cigarette smoker (40+ cigs/day)
- ☐ Heavy cigarette smoker (20-39 cigs/day)
- ☐ Moderate cigarette smoker (10-19 cigs/day)
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Trivial cigarette smoker (less than one cigarette/day)
- ☐ Pipe smoker
- ☐ Cigar Smoker

Started using tobacco in: __________ Stopped using tobacco in: __________

Family Health History	First Name	Year of birth	Serious illnesses or other medical conditions and age at onset	If deceased list cause and age at death
Mother's Family		[if known]	[if known]	[if known]
Mother				
sibling				
sibling				

Father's Family

Father				
sibling				
sibling				

Your Family

You				
sibling				
sibling				
child				
child				

Today's Date ____________________

Patient's Printed Name ____________________

Patient's Signature (over 17 years old) ____________________

Guardian Signature (under 18 years old) ____________________

Guardian Printed Name ____________________