Chiropractic Intake Form

Name: _____ Phone: _____ DOB: _____ SS#: _____

Marital Status: _____ Height: _____ Weight: _____ Email: _____ Occupation: _____

Address: _____ City/State/Zip: _____ Referral: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

The Basics:

Please check any of the following that are a part of your lifestyle:

- ☐ Alcohol
- ☐ Drugs
- ☐ Tobacco
- ☐ Stress
- ☐ Marijuana
- ☐ Occupational Hazards
- ☐ Regular Exercise
  - Type: _____ Frequency: _____
  - Type: _____ Frequency: _____

Please check any of the following that are a part of your diet:

- ☐ Coffee/ Tea
- ☐ Soft Drinks
- ☐ Fruit Juices
- ☐ Salty foods
- ☐ Artificial Sweeteners
- ☐ Sugar

Appetite:
- ☐ Low
- ☐ Average
- ☐ High

Protein Intake:
- ☐ Low
- ☐ Average
- ☐ High

Glasses of water per day: _____

Please describe what your average daily menu looks like (Breakfast, Lunch, Dinner, and any Snacks)

Have you had chiropractic care before? ☐ Yes ☐ No

Chinese herbal medicine? ☐ Yes ☐ No

Reason for your visit today: _____

Is it getting worse? ☐ Yes ☐ No

What seems to make it worse? _____

Does it bother you when your: ☐ Sleep ☐ Work ☐ Other Specify: _____

What seemed to be the initial cause? _____

Please check any of the following that are applicable to your general symptoms:

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Recent weight gain/loss
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Bleed or bruise easily
- ☐ Muscle cramps
- ☐ Vertigo/ Dizziness
- ☐ Bodily heaviness
- ☐ Cold hands or feet (poor circulation)
- ☐ Shortness of breath
- ☐ Chills
- ☐ Fever

Medical:

Are you under the care of a physician now? ☐ Yes ☐ No If yes, for what? _____

Physician's name: _____ Physician's phone: _____

Other Concurrent Therapies: _____

Health Insurance Info:

Insurance Co. Name: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Medicare Info:

Insurance Co. Name: _____ Policy#: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Pharmaceuticals taken in the last 2 months: _____

Vitamins/ Supplements taken in the last 2 months: _____

Your Past Medical History: **Please mark any of the following you **have or have experienced.**

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes (Types: _____)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis (Type: _____)
- ☐ Herpes (Type: _____)
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker (Date: _____)
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough
- ☐ Others, please specify:

List any surgeries you have had (if not applicable please write"NA")

List any major traumas you have had-car accidents, falls, etc.- (if not applicable please write"NA)

Family Medical History: Please check all that apply:

- ☐ Allergies:
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Cancer:
- ☐ Depression
- ☐ Heart Disease
- ☐ Seizures
- ☐ Stroke

Gynecology:

Age menses began: _____ Date of last PAP: _____

Length of cycle: _____ Date last period began: _____

Do you experience any menstrual symptoms (e.g., pain, irregularity) that we should be aware of? ☐ Yes ☐ No

If yes, please specify:

Please list any other symptoms you are experiencing below:

Additional Symptoms: **Please mark any of the following you **have or have experienced.**

- Eye strain
- Glasses (What age:____)
- Eye pain
- Red eyes
- Itchy Eyes
- Spots in eyes
- Poor vision
- Blurred vision
- Night blindness
- Myopia or Presbyopia
- Glaucoma
- Cataracts
- Teeth Problems
- Grinding Teeth
- TMJ
- Facial pain
- Gum Problems
- Sores on lips or tongue
- Dry Mouth
- Excessive saliva
- Sinus problems
- Excessive phlegm (Color:_____)
- Recurent sore throat
- Swollen glands
- Lumps in throat
- Enlarged thyroid
- Nosebleeds
- Ringing in ears (High or Low)
- Poor hearing
- Earaches
- Headaches
- Migraines
- Concussions
- Difficulty breathing when laying down
- Tight chest
- Difficult Inhalation or Exhalation
- Cough
- Coughing up blood
- Blood Clots
- Fainting
- Chest pain
- Tachycardia
- Irregular Heartbeat
- Nausea
- Vomiting
- Acid Regurgitaion
- Gas
- Hiccups
- Bloating
- Bad breath
- Diarrhea
- Constipation - Laxative use? _____
- Kind_____ Frequency_____
- Black stools
- Rectal pain
- Bloody Stools
- Anal fissures
- Mucus in stools
- Hemorrhoid
- Itchy anus
- Intestinal pain or cramping
- Burning anus
- Neck/ shoulder pain
- Muscle pain
- Back pain Upper Lower
- Joint pain
- Rib pain
- Limited range of motion
- Hives
- Rashes
- Ulceration
- Psoriasis
- Acne
- Dandruff
- Eczema
- Itching
- Hair loss
- Change in hair/skin texture
- Fungal infections
- Numbness
- Tics
- Poor memory
- Anxiety
- Irritability
- Abuse survivor
- Considered/ attempted suicide
- Seeing a therapist
- Pain on urination
- Frequent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Venereal disease
- Bedwetting
- Kidney Stones
- Increased/ decreased libido
- Impotence
- Premature ejaculation
- Nocturnal emission

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctor's of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working as the clinic or office listed.

I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with the doctor of chiropractic named below and/or with other office or clinic personnel.

I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures named above. I intend this consent form to cover the entire course of treatment for my present condition(s) and any future condition(s) for which I seek treatment.

To be completed by the patient:

_____

Print Patient's Name

_____

Signature of Patient

_____

Date Signed

_____

Authorized Provider Signature

_____

Date Signed

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or mentally incapacitated:

_____

Print Patient's Name

_____

Print Name of Patient's Representative

_____

Signature or Patient's Representative

As: _____

Relationship or Authority of Patient's Rep.

_____

Date Signed