CHIROPRACTIC INTAKE & HISTORY



PATIENT	INFORM	OITAN	I						
Patient Name					Employer	/ School			
		LAST N			_ Occupati	on			
Address	FIRST NAME		MIDDLE	INITIAL	Spouse's	Name			
City		ç	State		•	Employer			
Home Phone					•	Occupation			
Cell Phone						OF EMERGENCY			
Email									
Sex 🗖 M	☐ F Age		,		_ Relations	hip			
Married	☐ Widow	ed 🗖	Single	Minor	Contact N	Number			
☐ Separated	☐ Divorce	ed 🗖	Partnered		Who may	y we thank for ref	erring you?		
HOW CA	N WE HE	ELP YO							
What brings yo	ou in today? _								
If you are alrea	dy experiencir	ng a symptoi	m, what is it?						
How bad is it?				SYMPTO		3 4 5	6 7		ID INTENSE YMPTOM
What does it fo	eel like? (chec	k where app	oropriate)			\int_{Λ}	\int_{Λ}		
□ Numbness		Sharp							
☐ Tingling		Shooting				$(\delta) \times (\delta)$	(S) X)		
☐ Stiffness		Burning				0/ 1/0	° () (0	
□ Dull		Throbbing))((\)(/		
☐ Aching		Stabbing				(())	()?)		
ŭ		Ü				\	\ (\ /		
☐ Cramping		Swelling))		
□ Nagging		Otner							
IMPACT	OF YOU	R SYMI	PTOMS						
How is this syr	nptom / condit	tion interferir	ng with your li	fe? (check w	here appropriate)				
,	No Effect	Mild Effect	Moderate Effect	Severe Effect	, ,	No Effec	Mild t Effect	Moderate Effect	Seve Effec
Work					Energy				
Exercise					Attitude				
Recreation	_		_		Patience		_		
Relationships					Productivity				
Sleep					Creativity				
Self-Care					Other				
How committe	d are you to co	orrecting this	•	0 0	9 3	4 6	6 7	8 9	VEI

4	I	ILLNFS	S-WFI I	NESS CO	INITAC	JUM			
			<u> </u>	. 1200 00					
PDE				MFORT					
PRE- MATURE	Disease De	veloping -		ONE -	Wellne	ss Devel	oping —	→ HIGH	
DEATH			(FALSI	WELLNESS)				WEL	LNESS
0	1 2	3	4	5 6	7	8	9	10	
DISEASE Multiple medications		R HEALTH mptoms		IEUTRAL symptoms		OOD HEALTI gular exercis		OPTIMAL 100% f	
Poor quality of life Potential becomes limited	Dru	g therapy Surgery	Nutritio	on inconsistent cise sporadic	G	ood nutrition ness educati		Continuous of Active par	
Body has limited function	Losing n	ormal function		ot a high priority		nerve interfe		Wellness	
- H									
n the arrow diagram abo									
A. What number do you	think represent	ts your health	n today?						
B. In what direction is yo	ur health curre	ently headed?							
/hat are your health goals	?								
IMMEDIATE									
SHORT TERM .									
LONG TERM _									
LONG TERM =									
low many children do you	ı have?			•	• •	•		☐ Yes, I am (
low many children do you	ı have?			Number	of past pre	gnancies?		☐ Yes, I am o	
low many children do you childrens' ages? childrens' health concerns	ı have?			Number Health c	of past preg	gnancies? parding this	pregnand	· 	
low many children do you childrens' ages?childrens' health concerns	r have?			Number Health o	of past preconcerns reg	gnancies? larding this	pregnand	cy?	ve or have t
ow many children do you childrens' ages?	ess His	TORY	ssues	Number Health o	of past preconcerns reg	gnancies? larding this	pregnand y condition	cy?n that you hav	ve or have t
ow many children do you hildrens' ages?hildrens' health concerns HEALTH & ILLN AIDS/HIV Alcoholism	! have? ? ESS HIS	STORY Circulation Is	ssues	Number Health o	of past pred concerns reg eck the box daches / Mig t Disease	gnancies? larding this	pregnand y condition	n that you hav	ve or have h
iow many children do you childrens' ages? childrens' health concerns lEALTH & ILLN l AIDS/HIV l Alcoholism l Anxiety	ESS HIS	STORY Circulation Is Childhood III	ssues	Number Health of	eck the box daches / Mig t Disease	gnancies? larding this	y conditio	n that you have Ringing in E	ve or have h
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low many children do you childrens' ages?	ESS HIS	Circulation Is Childhood III Depression Diabetes Digestive Iss (Constipation/Dia Elbow/Wrist/	esues iness sues arrhea/GERD/IBS) /Hand Issues	Please ch Please ch Hear Hear Hear Hepr Hip I	eck the box daches / Mig t Disease atitis ssues une Issues	gnancies? larding this beside any graines	y condition	n that you have a Ringing in E Scoliosis Shoulder Is Stroke TMJ Issues	ve or have h Ears sues
How many children do you childrens' ages? Childrens' health concerns HEALTH & ILLN Alcoholism Anxiety Arteriosclerosis Arthritis Asthma/Allergies Back Pain	ESS HIS	Circulation Is Childhood III Depression Diabetes Digestive Iss (Constipation/Dia Elbow/Wrist/ Endocrine Is:	ssues sues surhea/GERD/IBS) /Hand Issues sues (Thyroid)	Please ch Please ch Hear Hear Hear Hepr Hip I	eck the box daches / Mig t Disease atitis ssues une Issues phatic Issue iple Sclerosi	gnancies? larding this beside any graines	y condition	n that you have a score of the	ve or have h Ears sues ues sis
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