Date: Patient #:

CHIROPRACTIC INITIAL INTAKE FORM

Name: _____ Occupation: _____

Birthdate: _____ Cell or home phone: _____

Physician: _____

Address: _____

HISTORY

Chief Complaint/Ailment _____

_____

Previous medical diagnostics? ☐MRI ☐US ☐ X Ray ☐CAT Scan ☐ Other _____

Have you received treatment for this before? Y / N When? _____

Are you receiving other treatments now for this? _____

List any surgeries: _____

Today, what is presentation of your symptoms? _____

_____

Trouble sleeping due to pain? Y / N Symptoms worse in a.m p.m.

Has your condition been getting: ☐better ☐same ☐worse?

Out of 10, what number best corresponds to your pain over the last 2 days? Zero is no pain and 10 is pain so intense you would go to the emergency department.

Worse: /10 Best: /10

Medications: _____

What **aggravates**/makes your condition worse? (mark only what applies to the last 2 days)

☐ bending	☐ Reaching	☐ sitting	☐ standing
☐ deep breathing	☐ coughing	☐ sneezing	☐ using keyboard
☐ raising from sitting	☐ lying	☐ stairs: up? Down? Both.	
☐ general movement	☐ walking	☐ in a prolonged position	
☐ worse in a.m.	☐ worse in p.m.	☐ worse as day progresses	
☐ driving	☐ movement in a sports activity/hobby		

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What **relieves**/makes your condition better? (mark only what applies in the last 2 days)

☐ heat or ice ☐ using mobility aid ☐ medication ☐ walking

☐ changing position ☐ rest from aggravating action ☐ movement including exercises

☐ better in a.m. ☐ getting off your feet ☐ improves as day progresses

MEDICAL INFORMATION

☐Arthritis	☐Diabetes	☐ History of Drug Abuse
☐High blood pressure	☐Anemia	☐ History of Alcohol Abuse
☐Hard of Hearing	☐ Reduced vision	☐ Anxiety / Depression
☐Heart troubles	☐ Cancer	☐ Hepatitis/HIV
☐Pacemaker	☐ Epilepsy/Seizures	☐ Bleeding or clotting problems
☐ Fibromyalgia	☐ History of Smoking	☐ Unexplained weight loss
☐ Difficulties swallowing	☐ Shortness of Breath	☐ Pregnancy
☐ Osteoporosis	☐ Stroke	☐ Previous concussions

Do you have any allergies that require an epi-pen? Y / N Do you react to latex? Y / N

If this is an MVA, date of accident _____ Were police involved? Y / N
Did your air bag deploy? Y / N Did you travel to hospital in an ambulance? Y / N

Is there is something you'd like to do better by the end of the therapy? What is your goal? _____

_____

This information is confidential and remains part of your chart.

Your signature: Form reviewed with:

Fee schedule reviewed ☐

Consent to proceed with treatment ☐

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