NEW GEN CHIROPRACTIC

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____ _____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ **Birthday** _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Empoyer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

If you are already experiencing a symptom, what is it? _____

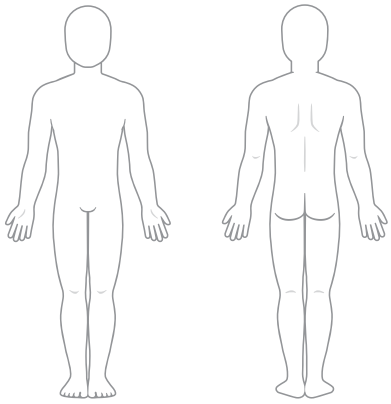
_____

How bad is it? How intense are your symptoms? (fill in the circle)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 NO SYMPTOMS — 10 INTENSE SYMPTOMS

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



What does it feel like? (Check where appropriate)

☐ Numbness ☐ Sharp ☐ Tingling

☐ Shooting ☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing ☐ Aching

☐ Stabbing ☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is the symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	**Energy**	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	**Attitude**	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	**Patience**	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	**Productivity**	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	**Creativity**	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	**Other** _____	☐	☐	☐	☐

How committed are you to correcting this issue? (fill in the circle)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 NOT COMMITTED — 10 VERY COMMITTED

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PATIENT WELLNESS ASSESSMENT

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? _____

Childrens' Age(s): _____

Childrens' health concerns: _____

Number of pregnancies: _____

Are you currently pregnant? ☐ No ☐ Yes ☐ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constpiation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Allergies (List)	Medications (List)	Supplements (List)

FAMILY HISTORY

☐ RA ☐ Heart Disease ☐ Diabetes

SURGERIES _____

ACCIDENTS/TRAUMA _____

Signature: _____ **Date:** _____