Intake Form

Lifestyle

Exercise	**Activity**	**Habits**
Hours per Day _________	*Sitting* Hours per day ______	*Tabacco* Uses per day __________
Light	*Standing* Hours per day ______	*Alcohol* Drinks per week ________
Moderate	*Manual Labor* Hours per day ______	*Soda* Drinks per week ________
Heavy		*High Stress*

Medications	Vitamins/Supplements	Allergies
_______________________________	_______________________________________	_______________________________
_______________________________	_______________________________________	_______________________________
_______________________________	_______________________________________	_______________________________
_______________________________	_______________________________________	_______________________________
none	*none*	*none*

Past Medical Conditions

(please check all that apply)

_____ Headaches/Migraines	_____ Joint Replacement	_____ Heart Disease
_____ Neck Pain	_____ Fused Joints	_____ Stroke
_____ Mid Back Pain	_____ Arthritis	_____ Cancer
_____ Low Back Pain	_____ Osteoporosis	_____ Diabetes
_____ Hip Pain	_____ Osteopenia	_____ Tumors
_____ Sciatica	_____ High Blood Pressure	_____ Seizure Disorder
_____ Pinched Nerve	_____ Pacemaker	_____ Blood/Clotting Disorder
_____ Herniated Disc	_____ Hernia	_____ AIDS/HIV
_____ Root Canal	_____ Dental Fillings	_____ Other Dental Procedures

Other ___________________________________

Are you pregnant? *Yes* *No* *N/A* If so, how many weeks? _______________

Please describe any of the following:

Surgeries ____

Major accidents/injuries ____

Anything else you would like the doctor to know ____

Patient or Guardian Signature ____ Date _____________________

Intake Form

Chief Complaint

Reason for today's visit ____

When did your complaint start? ____________________________________

What makes the condition worse? ________________________________

What makes the condition better? ________________________________

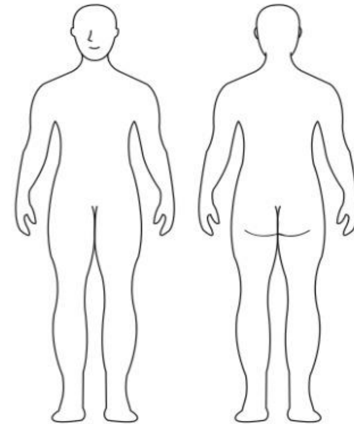
Please rate your symptoms ____
(1 = none, 10 = severe)

Type of pain: *Sharp* *Dull* *Aching*

Burning *Numbness* *Tingling*

Stiffness *Swelling*

(please mark affected areas)



Does the pain travel? ____

If so, from where to where? _______________________________________

Have you seen a chiropractor before? *Yes* *No* If so, how recently? ___________________________

Please describe any other concerns with your chief complaint ____

____

Are you currently experiencing any of the following:

_____ Headache or neck pain
_____ Dizziness
_____ Fainting
_____ Nausea or vomiting
_____ Double vision

_____ Numbness on one side of the face
_____ Difficulty swallowing
_____ Difficulty speaking
_____ Difficulty walking
_____ Rapid eye movement

(for doctor use only)

Patient or Guardian Signature ____ Date ______________________