CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name ______________________
LAST NAME

____
FIRST NAME MIDDLE NAME

Address ______________________

Suburb __________ Post Code __________

Mobile Phone ______________________

Email ______________________

Sex M F Age ______ Birthday ______

Occupation ______________________

Partner's Name ______________________

Emergency Contact (name & number):

____

Who may we thank for referring you?

____

HOW CAN WE HELP YOU?

What brings you in today? ______________________

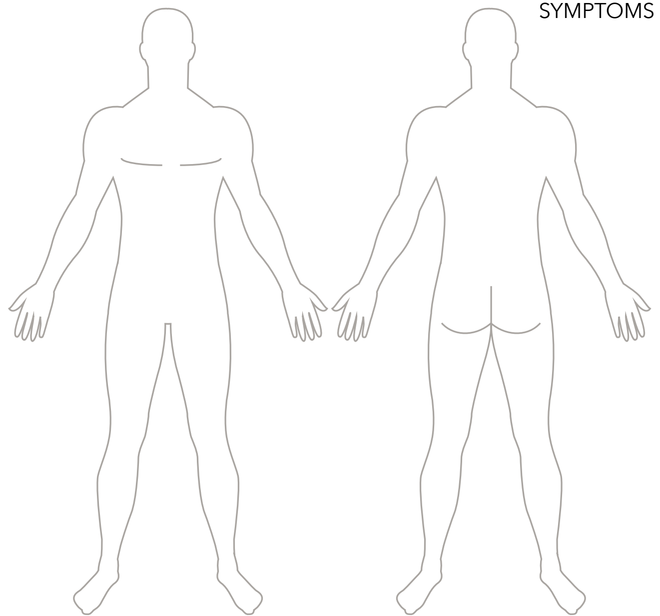
____

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

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle 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

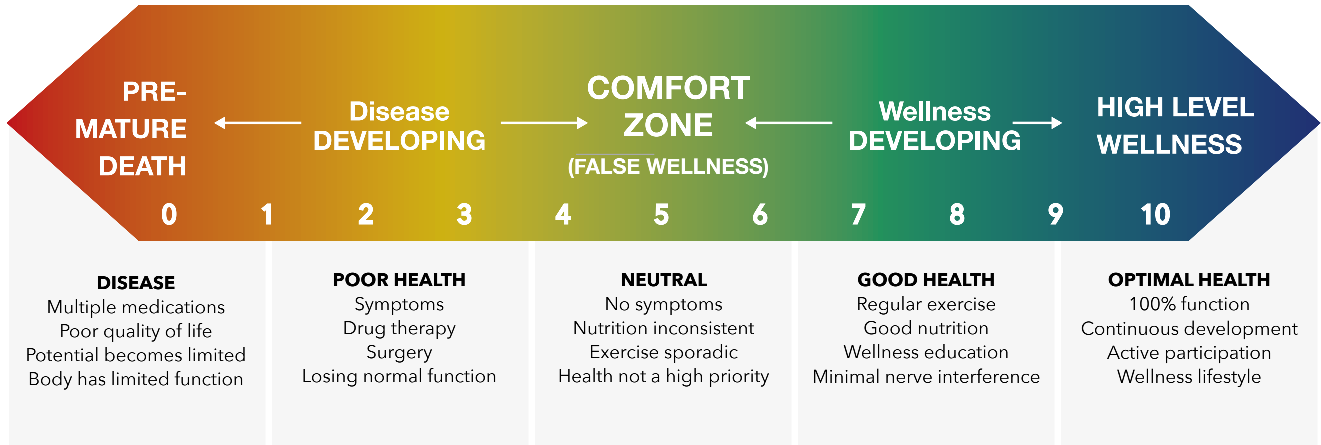
How is this symptom I condition interfering with your life? (check where appropriate)

	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? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITIED — VERY COMMITIED

CLIENT WELLNESS ASSESSMENT



DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications	Symptoms	No symptoms	Regular exercise	100% function
Poor quality of life	Drug therapy	Nutrition inconsistent	Good nutrition	Continuous development
Potential becomes limited	Surgery	Exercise sporadic	Wellness education	Active participation
Body has limited function	Losing normal function	Health not a high priority	Minimal nerve interference	Wellness lifestyle

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' ages? ______

Childrens' health concerns? ______

Are you currently pregnant? No Yes, I am due ______

Number of past pregnancies? ______

Health concerns regarding this pregnancy? ______

HEALTH & ILLNESS HISTORY

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

I acknowledge that any physical activity including assessment carries inherent but minimal risk of exacerbating my condition, and with this understanding I consent to undergo a physical Chiropractic examination for the purposes of diagnosing my condition and determining my state of function.

Signed ______________________________________ Date__________________