



CHIROPRACTIC PATIENT INTAKE FORM

PERSONAL INFORMATION			
TITLE: MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS. <input type="checkbox"/> MS. <input type="checkbox"/> DR. <input type="checkbox"/>	BIRTH DATE (m/d/y)	DATE	
FIRST NAME	LAST NAME	OCCUPATION	
ARE YOU MAKING A CLAIM FOR			
1) RECENT MOTOR VEHICLE ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO 2) WORK RELATED INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO			
HEALTH HISTORY - Please check any conditions/symptoms that you have or have had in the past			
<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> PAINFUL URINATION
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> POOR CIRCULATION
<input type="checkbox"/> BACK PAIN	<input type="checkbox"/> DIFFICULTY URINATING	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> RINGING OF THE EARS
<input type="checkbox"/> BLOODY/TARRY STOOL	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> LOSS OF SLEEP	<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/> BRUISE EASILY	<input type="checkbox"/> EAR ACHE	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> TREMORS
<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> ECZEMA/RASH	<input type="checkbox"/> MENTAL ILLNESS	<input type="checkbox"/> URGENCY TO URINATE
<input type="checkbox"/> COLITIS/CROHNS	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> VISION PROBLEMS
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FEVER	<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> WEAKNESS
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> NOSE BLEEDS	<input type="checkbox"/> WEIGHT LOSS
HEALTH HISTORY - Please check any conditions that you have been diagnosed with:			
<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> RESPIRATORY DISEASE
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> STROKE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> NEUROLOGICAL DISORDER	<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> AUTOIMMUNE DISEASE	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> OTHER _____
WOMEN ONLY : ARE YOU CURRENTLY PREGNANT ? <input type="checkbox"/> NO <input type="checkbox"/> YES DUE DATE _____			
FAMILY HISTORY - Please check any conditions that any blood relative has been diagnosed with:			
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OSTEOPOROSIS	
<input type="checkbox"/> AUTOIMMUNE DISEASE	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> RESPIRATORY DISEASE	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CANCER	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> STROKE	
<input type="checkbox"/> DIABETES	<input type="checkbox"/> NEUROLOGICAL DISORDER	<input type="checkbox"/> THYROID DISEASE	
LIST ALL SURGERIES, HOSPITALIZATIONS, AND INJURIES YOU HAVE HAD			
LIST ALL PRESCRIPTION/OVER-THE-COUNTER MEDICINE AND SUPPLEMENTS (vitamins/minerals/herbs) THAT YOU ARE CURRENTLY TAKING			
HAVE YOU SOUGHT TREATMENT FROM ANY OTHER HEALTH CARE PROFESSIONALS FOR THE CURRENT COMPLAINT? <input type="checkbox"/> YES <input type="checkbox"/> NO		TREATMENT RECEIVED	
HAVE ANY XRAYS, MRI, CT, OR ADVANCED TESTING BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO, IF YES PLEASE INDICATE			
HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes please complete the following			
CHIROPRACTOR'S NAME		LAST VISIT	
REASON FOR SEEKING CARE		RESULTS <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	