In Motion Chiropractic

PATIENT INTAKE FORM Today's Date: _____

Full Name: _____

Date of Birth: _____ SSN: _____

Address: _____

Cell #: _____ Home #: _____

Email: _____

Height: _____ Weight: _____

Relationship status: _____ Spouse/Partner Name: _____

Do you have children? _____ How many? _____

Emergency Contact: _____

Name Relationship Phone #

Who can we thank for sending you to us? _____

Occupation: _____ Years at this job: _____

Have you ever been adjusted by a Chiropractor? Yes ☐ No ☐

If yes, what was the reason for the visit? _____

_____

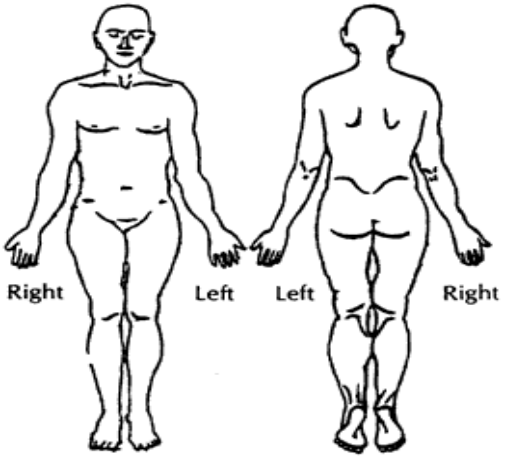
Health Habits & Lifestyle

Alcohol:	Daily	Weekly	Occasion	Never	Caffeine:	Daily	Weekly	Occasion	Never
Diet Foods:	Daily	Weekly	Occasion	Never	Rec. Drugs:	Daily	Weekly	Occasion	Never
Homemade Food:	Daily	Weekly	Occasion	Never	Exercise:	Daily	Weekly	Occasion	Never
Soda:	Daily	Weekly	Occasion	Never	Processed Foods:	Daily	Weekly	Occasion	Never
Water:	Daily	Weekly	Occasion	Never	Tobacco:	Daily	Weekly	Occasion	Never

Describe reason for today's visit: _____

_____

PAIN DIAGRAM



Please mark the location(s) of your pain using the following symbols:

N = numbness/tingling
^ = sharp/stabbing
B = burning
S = shooting/travelling
A = aching
O = other (describe)
T = tightness

When did you first notice it? _____ What caused it? _____

How is the condition now? Better ☐ Worse ☐ Same ☐ Comes and goes ☐

What makes it worse?

☐Driving
☐Walking
☐Sitting
☐Bending
☐Standing
☐Bowel Movement
☐Breathing
☐Coughing
☐Sleeping
☐Working
☐Exercising
☐Other _____

What makes it better?

☐Chiropractic
☐Rest
☐Lying Down
☐Sitting
☐Standing
☐Walking
☐Ice
☐Heat
☐Stretching
☐Massage
☐Medication
☐Nothing
☐Other _____

Rate your pain TODAY: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Rate your AVERAGE pain: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

My condition interferes with: Work ☐ Sleep ☐ Daily Routine ☐ Other Activities ☐

Describe: _____

Have you had this condition before? Yes ☐ No ☐ When? _____

Have you seen another doctor for this? Yes ☐ No ☐ When? _____

Were x-rays or other imaging studies performed? _____

Type of Treatment/ Results: _____

_____

_____

Personal Health History

List any medications or supplements you're currently taking (including over-the-counter)

_____

_____

_____

Have you ever had any surgeries or been hospitalized? Yes ☐ No ☐

When and for what? _____

_____

Please list any major injuries you've had, including childhood: (include dates) _____

_____

_____

_____

Health Checklist:

☐Allergies
☐Alcoholism
☐Anemia
☐Arteriosclerosis
☐Arthritis
☐Asthma
☐Ankle Swelling
☐Back Pain
☐Bronchitis
☐Bruise Easily
☐Cancer
☐Chest Pain
☐Cold Extremities
☐Constipation
☐Depression
☐Diabetes
☐Digestion Problems
☐Dizziness
☐Eye Pain
☐Fatigue
☐Frequent Urination
☐Headache
☐Hemorrhoids
☐Hot Flashes
☐High Blood Pressure
☐Irregular Cycle
☐Kidney Infection
☐Kidney Stones
☐ Loss of Memory
☐Loss of Balance
☐Loss of Smell
☐Loss of Taste
☐Nosebleeds
☐Pacemaker
☐Poor Posture
☐Sciatica
☐Shortness of Breath
☐Sinus Infection
☐Insomnia
☐Stroke
☐Swollen Joints
☐Thyroid Condition
☐Ulcers
☐Varicose Veins

What are your goals for care? _____

_____

_____

_____