Chiropractor Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Social Security #: _____ Gender: ○ Female ○ Male

Marital Status: ○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Race (Please check all that apply): ☐ Caucasian ☐ Asian ☐ Black ☐ Native American /Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other :

If other, specify: _____

Would you like to join our e-newsletter? ○ Yes ○ No

Preferred Language: ○ English ○ Spanish ○ Other :

If other, specify: _____

2. Who referred you?

_____

3. Emergency Contact Information

Name: _____ Relationship: _____ Phone Number: _____

4. Do you have Medical Insurance?

○ Private ○ Medicare ○ Medicaid ○ None

5. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

6. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender
○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

7. Is your Insurance through your work?
○ Yes ○ No

Workers Compensation Claim?
○ Yes ○ No

8. Is your current medical condition related to:

○ Personal injury ○ Car accident ○ Worker's compensation

9. What brings you in today?

10. Any inciting injury or trauma? | Date of trauma:

Anything make it worse?

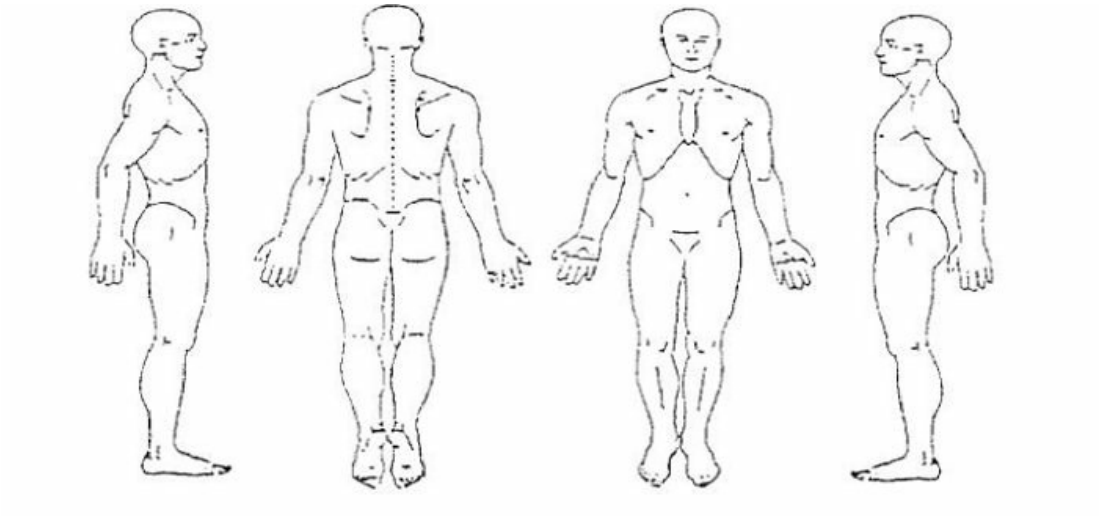
Is the problem worse:
○ Morning ○ Evening ○ with Activity ○ at Rest

11. Is this problem affecting your daily life, work or sleep?

○ Yes ○ No

12. If yes, please explain:

13. Please draw where you feel pain on the image below:



14. Do you experience:

☐ Muscle Cramps/Pain ☐ Joint Pain/Swelling
☐ Numbness/Tingling ☐ Stiffness

How severe is your pain:

_____

Are your symptoms:

○ Improving ○ Worsening ○ Stable

15. _____

16. **Have you been treated for this problem before?**

○ Yes ○ No

17. **If yes, have you been treated with:**

☐ Physical Therapy ☐ Surgery ☐ Chiropractor
☐ Exercise Routine ☐ Pilates ☐ Trigger Point Injection
☐ Medications ☐ Other:

If other, please specify:

_____

18. **Have you undergone any special tests for this condition (i.e. MRI, Xrays?)**

○ Yes ○ No

19. **If yes, please explain (include diagnosis and date):**

_____
_____
_____
_____

MEDICAL HISTORY

20. How would you rate your overall health?

○ Excellent ○ Good ○ Fair ○ Poor

How would you rate your stress level?

How would you rate your overall energy?

21. List any major injuries:

- ☐ Back
- ☐ Broken bones/fractures
- ☐ Car Accident
- ☐ Neck
- ☐ Severe fall
- ☐ Other:
- ☐ Head
- ☐ Disability

If other, please specify:

22. Have you had any Past surgeries?

○ Yes ○ No

23. If yes, please list past surgeries, year of surgery, and any important notes related to the surgery:

	Type of Surgery	Year	Notes/Comments
1			
2			
3			

24. Medical History (Check all that apply)

- ☐ Heart Disease
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ High Blood pressure
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Skin disorder
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Vertigo
- ☐ Thyroid disease
- ☐ Multiple Sclerosis
- ☐ Other Eye problems
- ☐ Osteoporosis
- ☐ Depression/Anxiety
- ☐ Seizures/Epilepsy
- ☐ Liver disease
- ☐ Dementia
- ☐ Low Blood Pressure
- ☐ Multiple sclerosis
- ☐ Bleeding disorder
- ☐ Colitis/Chron's disease
- ☐ Diabetes Type I or II
- ☐ Lupus erythema
- ☐ Cataracts
- ☐ Cancer
- ☐ Alcohol/Substance Abuse
- ☐ Muscle disorders
- ☐ Fibromyalgia
- ☐ Kidney Disease/Failure
- ☐ STDs
- ☐ Other:

If other, please specify:

REVIEW OF SYMPTOMS

In the following section, please check any symptoms that you currently experience.

25. General

- ☐ Fatigue
- ☐ Frequent Infections
- ☐ Heat or cold intolerance
- ☐ Unexplained weight loss or gain
- ☐ Difficulty with Balance
- ☐ Hot Flashes/Cold Sweats

26. Eyes

- ☐ Vision problems
- ☐ Sensitivity to Light
- ☐ Red/Dry/Itchy Eyes

27. Ear, Nose, Throat

- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Sinus Congestion
- ☐ Ringing/Buzzing in the Ears

28. Neurologic/Psychological

- ☐ Anxiety
- ☐ Depressed Mood
- ☐ Dizziness/Lightheadedness
- ☐ Facial Weakness
- ☐ Memory Problems
- ☐ Sleeping Problems
- ☐ Headaches
- ☐ Slurred speech
- ☐ Numbness/tingling

29. Gastrointestinal

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Loss of bowel control

30. Respiratory

- ☐ Bloody cough
- ☐ Snoring
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Excess sputum/mucus

31. Cardiovascular

- ☐ Ankle swelling
- ☐ Chest pain
- ☐ Leg pain when walking
- ☐ Difficulty walking a block
- ☐ Difficulty breathing while lying flat

32. Skin/Muscles

- ☐ Easy bruising/bleeding
- ☐ Joint pain/swelling
- ☐ Nail changes
- ☐ Muscle weakness
- ☐ Dry, itchy skin
- ☐ Skin rashes/hives

33. Do you/Have you:

	Yes	No	If Yes, Explain:
Have a history of weak bones (osteoporosis or osteopenia?)	Yes	No	
Have numbness/tingling or weakness in the arm or leg?	Yes	No	
Been diagnosed with cancer in the spine?	Yes	No	
Have an increased risk for having a stroke?	Yes	No	
Have any bone abnormality in your neck?	Yes	No	
Had sudden numbness in the groin region or loss of bowel or urine control?	Yes	No	

Medications

34. List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Name	Dosage	Frequency	Reason for Taking?
1				
2				
3				

35. Are you taking any:

Blood thinning medication?
○ Yes ○ No

Steroid medication?
○ Yes ○ No

36. Do you have any allergies?

○ Yes ○ No

37. If yes, please list:

	Allergic to?	Reaction
1		
2		

SOCIAL HISTORY

38. Do you:

	Yes/No/Past	If yes, How Much?	How Often?
Smoke?			
Drink alcohol?			
Drink caffeine?			
Use pain medications?			
Use recreational drugs?			

39. How many times a week do you exercise for 30 minutes or more:

_____

40. What do you do for work?

_____

Is there significant stress in your job?
○ Yes ○ No

If yes, explain:

_____

Does your job consist mostly of:
☐ Sitting ☐ Computer Work ☐ Standing
☐ Heavy lifting ☐ Other:

If other, please specify:

_____

41. Female Only

Menopause?
○ Yes ○ No

Hormone replacement?
○ Yes ○ No

Are you pregnant?
○ Yes ○ No

Trying to get pregnant?
○ Yes ○ No

#Pregnancies: _____

Live Births: _____

#Abortions: _____

#Miscarriages: _____

Do you have:
☐ Irregular Periods ☐ Cramps ☐ Abnormal Bleeding ☐ Breast Pain ☐ UTI ☐ Urine Incontinence

42. Male Only

Do you have:
☐ Erection Problems ☐ Urinary Problems ☐ Prostate Problems ☐ Testicular/Scrotal Pain

43. Weight: Height:

_____