Patient Intake

Name *

Date of Birth *

Gender

- [ ] Male
- [ ] Female

Phone Number *

Email *

Home Address *

Emergency Contact

Emergency Phone Number

Occupation

At work, do you primarily

- [ ] Sit
- [ ] Stand
- [ ] Repetitive tasks

Please select any treatments you have had in the past *

- [ ] Chiropractic
- [ ] Acupuncture
- [ ] Massage Therapy
- [ ] Cupping
- [ ] Reiki
- [ ] Physical Therapy
- [ ] Other:

Who is your primary care physician? (Name, Practice, Phone Number)

Medications

Hospitalization, Operations and Significant Traumas (Auto Accident, Work Injury, Etc)

How did you hear about us?

Current State of Health

What are your complaints? *

When did the condition start?

What is your pain on a scale of 1-10?

Select a value

How did the problem start?

- [ ] Suddenly
- [ ] Gradually
- [ ] Post-Injury
- [ ] Post-Surgery
- [ ] Other:

Have you received care for this current condition?

- ( ) Yes
- ( ) No

If yes, please specify

What makes the problem better?

What makes the problem worse?

Tell Us About Your Past Medical History

Please Mark The Check Box If You Previously Suffered From These Conditions.

- [ ] Asthma
- [ ] Arteriosclerosis
- [ ] Cancer
- [ ] Epilepsy/Seizures
- [ ] Fibromyalgia
- [ ] Gout
- [ ] Hepatitis
- [ ] HIV
- [ ] Pacemaker
- [ ] Chronic Fatigue
- [ ] Diabetes
- [ ] Emphysema
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Herpes
- [ ] Ulcers
- [ ] Other:
- [ ] Appendicitis
- [ ] High Cholesterol
- [ ] High Blood Pressure
- [ ] Paralysis
- [ ] Pneumonia
- [ ] Stroke
- [ ] Parkinson's Disease

Cardiovascular Symptoms, Signs & Diseases

- [ ] High Blood Pressure
- [ ] Heart Beating Fast
- [ ] Swelling of Hand/Feet
- [ ] Fainting
- [ ] Low Blood Pressure
- [ ] Heart Palpitations
- [ ] Phlebitis
- [ ] Left Arm Pain
- [ ] Irregular Heart Beat
- [ ] Cold Hand/Feet
- [ ] Chest Pain
- [ ] Varicose Veins

Respiratory Signs & Symptoms

- [ ] Dry Cough
- [ ] Phlegmy
- [ ] Wet Cough
- [ ] Pneumonia
- [ ] Bronchitis
- [ ] Asthma

- [ ] Pain When Breathing Deep
- [ ] Short of Breath
- [ ] Chest Tightness
- [ ] Post Nasal Drip
- [ ] Labored Breathing
- [ ] Breath Feels Hot

GastroIntestinal

- [ ] Nausea
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Bloating
- [ ] Abdominal Pain/Cramp
- [ ] Hiccup
- [ ] Acid Regurgitation
- [ ] Belching
- [ ] Indigestion
- [ ] Bad Breath
- [ ] Rectal Pain
- [ ] Anal Fissures
- [ ] Itchy Anus
- [ ] Hemorrhoids

Gynecological & Obstetrics (Women Only)

- [ ] Currently Pregnant
- [ ] Irregular Menses
- [ ] Menstrual Clots
- [ ] No Menstrual Cycle
- [ ] Endometriosis
- [ ] Ovarian Cysts
- [ ] PCOS
- [ ] PMS
- [ ] Uterine Fibroids

Please check all that apply

- [ ] Previous Live Births
- [ ] Premature Births
- [ ] Miscarriages
- [ ] IVF
- [ ] IUD

Musculoskeletal

What Areas Are Painful?

- [ ] Head
- [ ] Neck
- [ ] Shoulder
- [ ] Upper Back
- [ ] Middle Back
- [ ] Lower Back
- [ ] Ribs
- [ ] Wrist
- [ ] Hip
- [ ] Upper Leg
- [ ] Side of Leg
- [ ] Lower Leg
- [ ] Knee
- [ ] Ankle
- [ ] Foot
- [ ] Fingers
- [ ] Toes
- [ ] Groin
- [ ] General Muscle Weakness
- [ ] Muscle Tightness
- [ ] Full Body Aches/Pain

Neuropsychological

Do You Feel Numbness?

- [ ] Face
- [ ] Shoulder
- [ ] Arms
- [ ] Wrists
- [ ] Fingers
- [ ] Toes
- [ ] Legs
- [ ] Ankles
- [ ] Foot

General Symptoms

- [ ] Dizziness
- [ ] Loss of Balance
- [ ] Lack of Coordination
- [ ] Memory Loss
- [ ] Tremors
- [ ] Panic Attacks

Your Health Goals

What are your top three health goals?

Is there anything else you would like to tell us?

Any questions or concerns you want to be sure to ask today?

Patient Signature *

Date *