Medical Intake Form

NAME: _____ Height: _____ Weight: _____

Have you had previous Chiropractic Care: Yes _____ No _____

Do you exercise weekly: Yes _____ No ____

Do you smoke: Yes _____ , if so how often _____ No _____

Do you drink alcohol: Yes _____ , if so how often _____ No ____

Do you use or have used recreational drugs: Yes _____ , if so how often _____ No ____

Hospitalizations (include year and reason): _____

_____

_____

Have you had any X-rays / MRI / CT Scans (include year and location) _____

_____

_____

List of Medications (if you have a copy of your medications, the front desk staff can make a copy for our records, otherwise, please list medications below): _____

_____

_____

Surgeries: (Please circle all that apply)

Hysterectomy	Heart Bypass	Cholecystectomy	Tonsillectomy	Sinus
Appendectomy	Cataract	Hiatal Hernia	Inguinal Hernia	Lasix
Skin Cancer	Carpal Tunnel	Neck Surgery	Back Surgery	Biopsy

Arthroscopic Surgery

Hip Replacement (L / R / Both) Knee Replacement (L / R / Both)

Other _____

Allergies:

☐ Sulpha	☐ Penicillin	☐ Dairy	☐ Gluten
☐ Nuts	☐ Seasonal	☐ Latex	☐ Bees

Other: _____

History Questionnaire

In your own words, what is your chief complaint that brings you in today? _____

_____

Have you had more than one episode of pain or symptoms? Yes _____ No _____

If yes, how often does the episode occur? _____

If yes, how much time between episodes? _____

If yes, are the episodes **increasing** or **decreasing** or the **same** in intensity? (circle one)

What caused the pain to start? _____

When did it start? _____

Where do you feel the pain? _____

Has the pain spread? (if yes, to where) _____

What makes the symptoms worse? AM or PM (circle one)

- ☐ Sitting ☐ Walking ☐ Rising ☐ On the move
- ☐ Standing ☐ Lying ☐ Rest

What makes the symptoms better? AM or PM (circle one)

- ☐ Sitting ☐ Walking ☐ Rising ☐ On the move
- ☐ Standing ☐ Lying ☐ Rest

How would you describe your pain?

- ☐ Cramping, dull, aching ☐ Sharp, shooting ☐ Constant
- ☐ Burning, pressure, stinging, aching ☐ Deep, nagging, dull ☐ Intermittent
- ☐ Sharp, bright, lighting like ☐ Throbbing, diffuse ☐ Occasional

Do you experience any of the following symptoms, and where?

- ☐ Numbness: _____
- ☐ Tingling: _____
- ☐ Weakness: _____

Have you received any treatment for this complaint? Yes or No (circle one)

If yes, what treatment? _____

Did it help? Yes or No (circle one)

If you were involved in an accident, describe **when** and **how** it happened: _____

_____

Is this a work-related injury / did it happen at work? Yes or No (circle one)

Medical Information: to the best of your knowledge, do you have or have had:

Organs:

- ☐ Aneurysms
- ☐ Angina/Chest Pain
- ☐ Asthma
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sarcoidosis
- ☐ Sinus Surgery
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Change in Appetite
- ☐ Diarrhea
- ☐ Kidney Stones

Disease/Symptoms:

- ☐ Raynaud's
- ☐ Crohn's Disease
- ☐ Systemic Lupus Erythematosus
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Lyme Disease
- ☐ Diverticulitis
- ☐ Multiple Sclerosis
- ☐ Cholecystitis
- ☐ Thyroid Disease
- ☐ Peripheral Vascular Disease
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Gout
- ☐ GERD
- ☐ Hepatitis
- ☐ IBS
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Seizures
- ☐ Blood Clots
- ☐ Blood Disorders
- ☐ Bruising
- ☐ Headaches
- ☐ Migraines
- ☐ Leukemia
- ☐ Bell's Palsy

Have you Had or Do you Have:

- ☐ Stents
- ☐ Stroke
- ☐ TIA (mini stroke)
- ☐ Sinusitis
- ☐ Ear Infection
- ☐ Cataract(s)
- ☐ Numbness
- ☐ Visual changes
- ☐ Retinal Detachment
- ☐ Tumors
- ☐ History of Chemotherapy or Radiation
- ☐ STD
- ☐ Urination (blood)
- ☐ Head Injury
- ☐ Visual changes
- ☐ History of Trauma
- ☐ Scleroderma
- ☐ Skin Rash
- ☐ Shingles

Females:

- ☐ Ovarian Cysts
- ☐ Tubal Ligation
- ☐ Abnormal periods
- ☐ Breast Lumps
- ☐ Breast Cancer
- ☐ Uterine Fibroids
- ☐ Menopause-post
- ☐ C-Section
- ☐ Pregnancy
- ☐ Currently pregnant

Males:

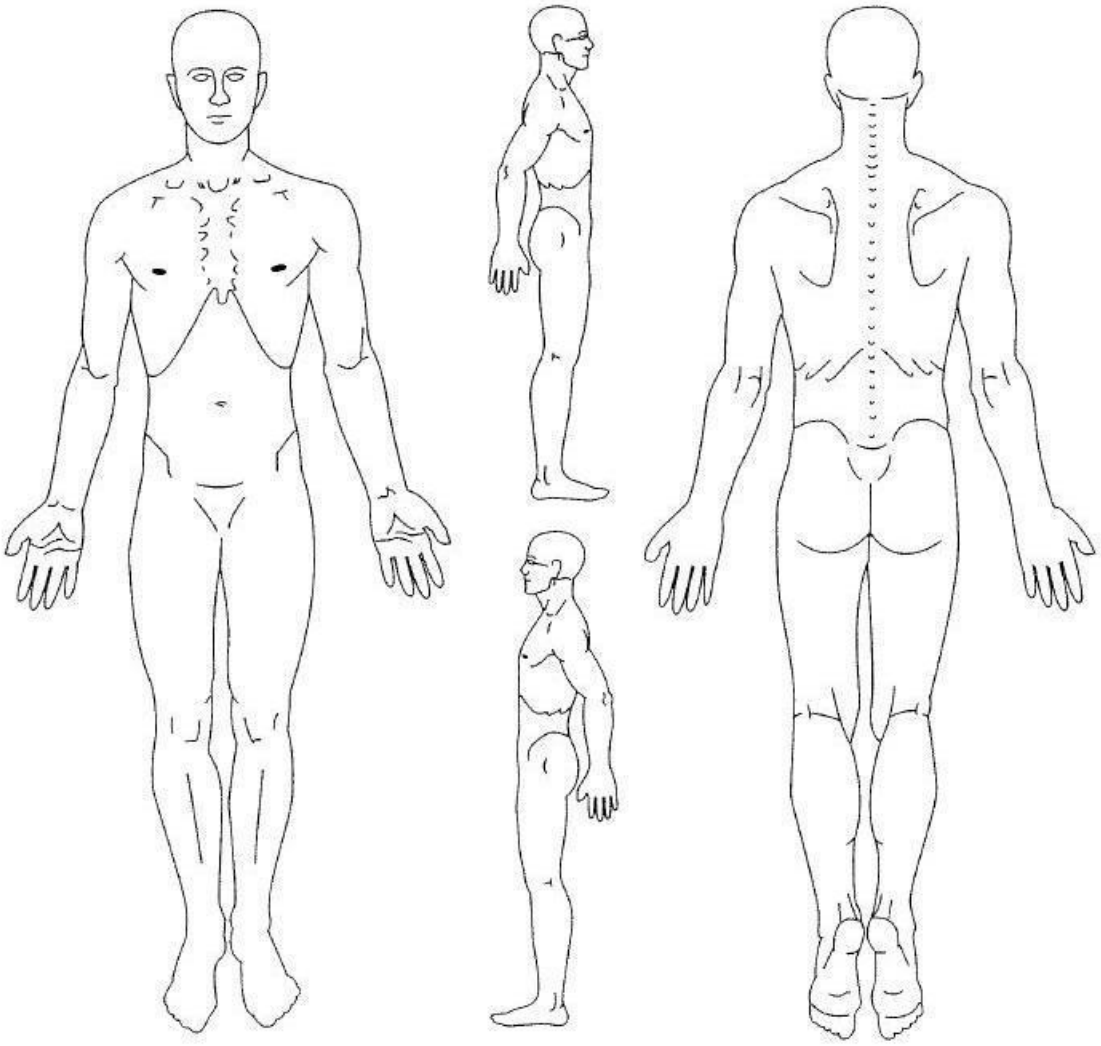
- ☐ Vasectomy
- ☐ Prostate Cancer
- ☐ Prostate Hypertrophy

Family History:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Problems

☐ Rheumatoid Arthritis ☐ Back Surgery

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing?
0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #10:

_____

_____

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

___ I am looking to resolve my symptoms and then go on to “fix the cause” of my problem

___ I am looking to take care of my problem and then go on to “achieve optimal health and wellness”