

Back In Action Chiropractic Patient Intake

Name _____ Sex M F Date _____

Address _____ City _____ State & Zip _____

H. Phone(_____) _____ W. Phone _____ Date of Birth _____ Age _____

Referred by _____ Social Security # _____

Occupation _____ Status: ___Single ___ Married ___Divorced ___Separated

E-mail _____ How did you find us? _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

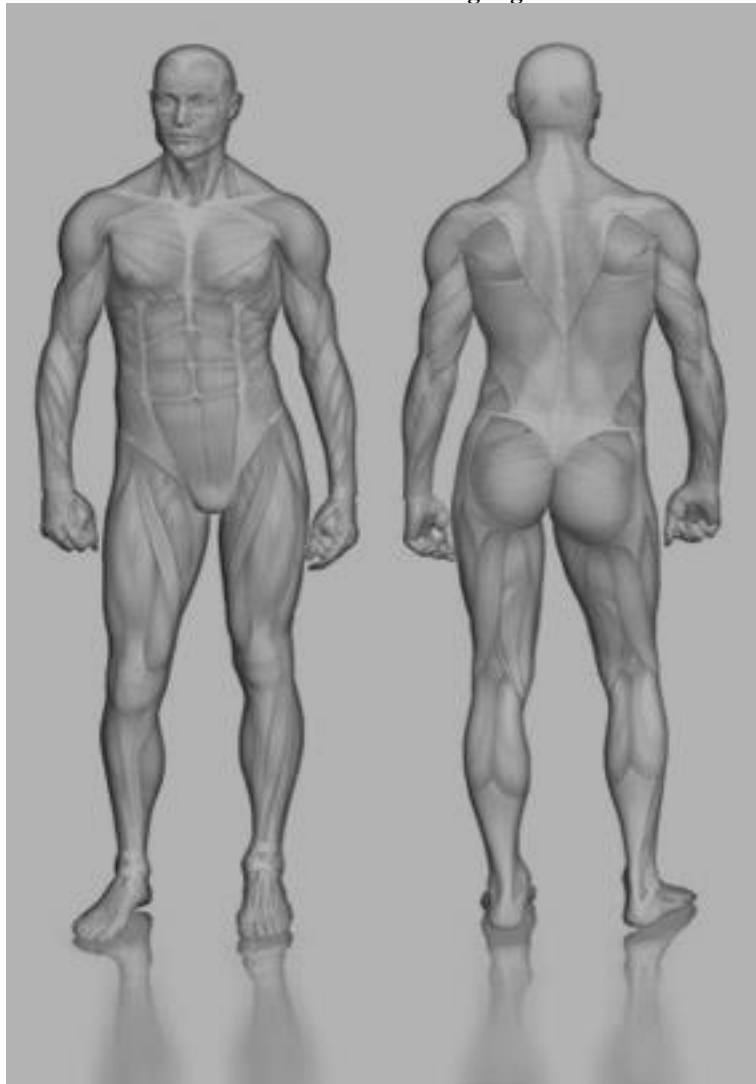
Other factors contributing to the primary and secondary reasons: _____

1. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please indicate the areas of pain with X's and areas of numbness or tingling with O's



Please **Circle** the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

4. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death

Age at death

5. Social and Occupational History:

A. Level of Education:

high school

some college

college graduate

post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____ Date _____