



Health Intake Form

Date: _____

Referred by: _____

Patient Name: _____ Social Security #: _____

Home/Work #: _____ Cell #: _____ Email: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation & Employer: _____

Marital Status: Married Single Divorced Widowed Number of Children: _____

Significant Other's Name: _____ Significant Other's Occupation: _____

Have you previously had Chiropractic Care? _____ If yes, when? _____ Did it help? _____

List your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Please describe work activities that may be causing your complaint _____

Please explain any other activities outside of work, which may have caused these complaints? _____

If this is due to an injury or accident, when did it happen? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your condition worse? _____

Have you been involved in an auto accident in the last 12 months? _____

Medications you take now: Aspirin Pain Killers Tranquilizers Insulin Birth Control Pills Other (please list) _____

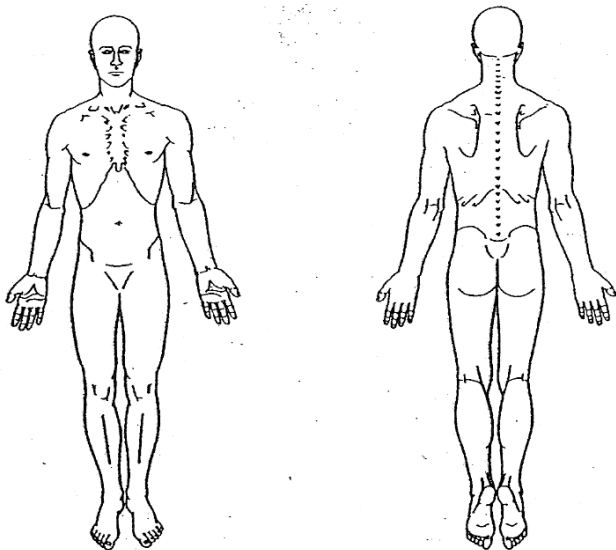
People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- RELIEF CARE: Symptomatic relief of pain or discomfort
- CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms
- COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition

Patient signature: _____

Additional Information on other side →

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity, which brings on or aggravates the pain. For example, describe as dull, sharp, constant, off & on, when standing, when sitting, etc.



Check appropriate squares (x) past or (✓) present condition:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Mental, emotional conditions | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Kidney troubles |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Acne | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Head colds | <input type="checkbox"/> Eczema | <input type="checkbox"/> Cough | <input type="checkbox"/> Dysentery |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Adenoids | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ruptures |
| <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Chronic tiredness | <input type="checkbox"/> Ringing ear | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Laryngitis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Sinus troubles | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bladder troubles |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Congestion | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Ear ache | <input type="checkbox"/> Croup | <input type="checkbox"/> Gall bladder condition | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Stomach troubles | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Shingles | <input type="checkbox"/> Change of life symptoms |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Liver condition | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Weakness in legs | <input type="checkbox"/> Fever | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Difficult urination |
| <input type="checkbox"/> Lowered resistance | <input type="checkbox"/> Hemorrhoids (piles) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Diabetes | | | <input type="checkbox"/> Frequent urination |

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN, SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses travel cards and provides care in an “open door” adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patient’s and staff. This environment is used for ongoing care and is not the environment for taking patient’s histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/address you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Patient’s Signature _____ Date _____

I have been offered a copy of the Café of Life’s HIPAA privacy act, and I may obtain one for my personal use at any time.

Patient’s Signature _____ Date _____