CHIROPRACTIC HEALTH CENTER

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Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code _____
Primary Phone _____ Work Phone: _____

DOB _____ E-mail Address: _____
Have you received previous chiropractic care? _____
Who may we thank for referring you? _____

Occupation: _____ Employer: _____

Gender: Male Female Marital Status: M S D W

Spouse/Significant other's Name: _____

Spouse/Significant other's Employer: _____

Number of Children & Ages Previous Chiropractic Care?
Name: _____ Age: _____ Y N Reason _____
Name: _____ Age: _____ Y N Reason _____
Name: _____ Age: _____ Y N Reason _____
Name: _____ Age: _____ Y N Reason _____

PATIENT HEALTH PROFILE

Accumulations of physical, chemical and emotional stress can show up as acute or chronic symptoms.

***Current Complaints/Present Concern:**

_____

Concern began: _____

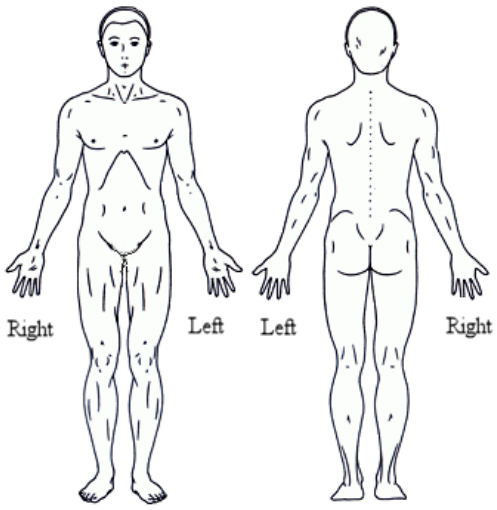
If there is pain associated with concern please elaborate. _____

Is your concern progressing in any way? _____

Other Healthcare Providers seen for this concern? _____

Any home remedies? _____

Please mark on the pictures below where you are experiencing symptoms/concerns.



If applicable, please **circle** degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Please circle the descriptions that apply to your concern
Numbness
Dull Ache
Burning
Sharp/Stabbing
Pins, Needles
Other _____
What activities aggravate your condition/pain?
_____
What activities lessen your condition/pain?
_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with work? _____
Sleep? _____Routine? _____Other? _____
Is this condition progressively getting worse? _____
_____

Other symptoms/concern: **Please Circle where Applicable**

Headaches	Stiff Neck	Pins & Needles in Legs	Pins & Needles in Arms
Numbness in Fingers	Numbness in Toes	Shortness of Breath	Buzzing in Ears
Fatigue	Depression	Lights Bother Eyes	Loss of Memory
Ears Ring	Neck Pain	Sleeping Problems	Back Pain
Nervousness	Tension	Irritability	Chest Pain
Dizziness	Fever	Fainting	Loss of Smell
Loss of Taste	Diarrhea	Constipation	Feet Cold
Hands Cold	Stomach Upset	Cold Sweats	Difficulty Balancing
Digestive Concerns	Nausea	Mood Changes	Cognitive Concerns

Have you sought medical care for any of the symptoms circled on the previous page?_____
_____

If so, how was the issue/concern corrected?_____

Have you had surgery?_____What?_____When?_____
_____

The human body is designed to be healthy. Throughout life, stresses and traumatic events occur that affect your spine/nerve system and therefore your health expression. These stresses may be PHYSICAL, CHEMICAL or EMOTIONAL in nature. Understanding the physical, chemical and emotional stresses that have acted upon your spine and nerve system assists us in serving you.

Let's begin at birth when you may have had stress placed on your spine and nerve system.

*Birth – Age 5

Yes	No		Patient Comment
		1. Pregnancy	
( )	( )	Did your mother: smoke or drink alcohol	_____
( )	( )	Have a proper diet?	_____
( )	( )	Exercise?	_____
( )	( )	Experience any falls or injuries?	_____
( )	( )	Experience any physical and/or mental abuse?	_____
		2. Birth Process	
( )	( )	Was your birth traumatic?	_____
( )	( )	Was the delivery long?	_____
( )	( )	Was the delivery difficult?	_____
( )	( )	Forceps?	_____
( )	( )	C-section?	_____
( )	( )	Breach/cephalic?	_____
( )	( )	Home birth?	_____
( )	( )	Hospital birth?	_____
( )	( )	Mother given drugs during delivery? (Epidural, etc.)	_____
( )	( )	Was labor induced?	_____
( )	( )	Premature?	_____
		3. Growth & Development	
( )	( )	Were you breast-fed?	_____
( )	( )	Were you vaccinated?	_____
( )	( )	Any major childhood illnesses?	_____
( )	( )	Did you fall out of bed?	_____
( )	( )	Accidents?	_____
( )	( )	Surgeries?	_____
( )	( )	Drugs/prescriptions?	_____
( )	( )	Child abuse?	_____
( )	( )	Physically disciplined?	_____
( )	( )	Other traumas? What? When?	_____

As you increased the layers of stresses you probably began to experience symptoms.

*Age 5 – Present

Yes	No				
( )	( )	Did/do you smoke?	_____		
( )	( )	Did/do you drink any alcohol?	_____		
( )	( )	Diet (do you eat healthy foods)?	_____		
( )	( )	Exercise regularly?	_____		
( )	( )	Interrupted Sleep patterns?	_____		
		Sleeping posture:	Side	Stomach	Back

Yes	No		
( )	( )	Did/do you have occupational stress?	_____
( )	( )	Physical stress?	_____
( )	( )	Mental/emotional stress?	_____
( )	( )	Have you been in accidents?	_____
( )	( )	Have you had surgery?	_____
( )	( )	Jaw/teeth problems?	_____
( )	( )	Eye problems?	_____
( )	( )	Hearing problems?	_____
( )	( )	Hobbies/Sports injuries?	_____
( )	( )	Other traumas?	_____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	( )	( )	( )	( )	( )
Mother's Side	( )	( )	( )	( )	( )

Chiropractic Health Center provides three types of care. The ultimate goal is for everyone to have lifetime wellness for themselves and their entire family. To get there, the first phase is ***Initial Intensive Care*** *that corrects the most recent layer of Spinal and Neurological stress (Vertebral Subluxation Complex). This care usually reduces or eliminates the concern/symptoms. Then* ***Reconstructive Care*** *begins, which aims to address the years of stresses/damage that were accumulating when there were few symptoms. And finally, Chiropractic offers a genuine approach to* ***Wellness Care****, assisting the body in its efforts to reach greater possibilities in health.*

As a result of becoming a practice member, I would like to (please check all that apply)

( ) Address my present concern only.
( ) Address my present concern and prevent its return.
( ) Work toward a healthier body by keeping my nerve system healthy
( ) Live an overall healthier lifestyle

Please rate your level of commitment to achieving your goals:

1 2 3 4 5 6 7 8 9 10
Not motivated Very Motivated

Patient
Signature_____ Date_____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name**: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail
Preferred telephone (Home/ Cell/ Work) #_____

DOB: __/___/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Smoking Start Date: ***Smoking End Date:***

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian/ Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

***Medications and dosages were supplied by the patient**

Do you have any medication allergies?

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____

Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____