



CHIROPRACTIC INTAKE FORM

DATE: _____

PATIENT INFORMATION

NAME: _____ AGE: _____ D.O.B.: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK / CELL PHONE: _____

MAY WE LEAVE YOU A MESSAGE? IF SO, WHERE? Home / Work / Cell / None

MAY WE SEND YOU EDUCATIONAL NEWS OR CLINIC PROMOTIONS VIA E-MAIL? Yes / No
E-MAIL: _____

SEX: M / F MARITAL STATUS: Single / Married / Divorced / Widowed / Separated

OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S NAME: _____ OCCUPATION: _____

DO YOU HAVE CHILDREN? Yes / No IF YES, WHAT AGE(S)? _____

FAMILY PHYSICIAN: _____ CITY: _____ PHONE: _____

REFERRALS ARE OUR HIGHEST COMPLIMENT. PLEASE SHARE HOW YOU HEARD ABOUT US?

flyer one of our patients (who? _____)
 newspaper referral from doctor (which doctor? _____)
 website other (please explain: _____)
 sign yellow pages

DO YOU HAVE EXTENDED HEALTH COVERAGE? Yes / No

INSURANCE COMPANY: _____

IF YES, AMOUNT ELIGIBLE FROM INSURANCE: \$ _____

IS THIS CONDITION DUE TO AN ACCIDENT? Yes / No DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: Auto / Work / Home / Other: _____

TO WHOM HAVE YOU REPORTED YOUR ACCIDENT?

Auto Ins. (Company and adjuster's name? _____)
 Worker's Comp. (Adjudicator's name? _____)
 Employer (Contact Name? _____)
 Other (Please explain: _____)

PATIENT CONDITION

ARE YOU PREGNANT? Yes / No HOW FAR ALONG? _____ 1st PREGNANCY? Yes / No

REASONS/COMPLAINTS FOR SEEKING CHIROPRACTIC CARE:

Primary reason: _____

Secondary reason: _____

Other reasons: _____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? Yes / No WHO? _____

CITY? _____ DATE OF LAST VISIT? _____

FOR WHAT COMPLAINT(S)? _____

COMPLAINT RESOLVED? Yes / No / Somewhat

HAVE YOU HAD X-RAYS TAKEN IN THE PAST 5 YEARS? Yes / No

OF WHAT AREA(S)? _____

DO YOU WEAR CUSTOM_MADE ORTHOTICS OR FOOTWEAR? Yes / No

HAVE YOU BEEN TO ANY OTHER HEALTHCARE PRACTITIONER FOR YOUR *CURRENT*

COMPLAINT? YES / NO WHO? _____ PROFESSION? _____

WHEN DID THIS CONDITION BEGIN? _____ OCCURRED BEFORE? Yes / No

WHAT AGGRAVATES YOUR CONDITION(S)?

- Sitting
- Standing
- Bending
- Lifting
- Walking
- Sleeping
- Weather
- Other (Please explain: _____)

WHAT RELIEVES YOUR CONDITION(S)?

- Ice
- Heat
- Massage
- Stretches & exercise
- Bed Rest
- Walking
- Medications (Which? _____)
- Other (Please explain: _____)

IS IT GETTING: Better / Worse / Constant / Comes and goes

IS THE PAIN:

- Sharp
- Dull
- Numb
- Tingling
- Aching
- Shooting
- Burning
- Throbbing
- Stiff
- Other (Please explain: _____)

ON A SCALE of 1-10 PLEASE CIRCLE THE SEVERITY OF YOUR PAIN:

No Pain < 0 1 2 3 4 5 6 7 8 9 10 > Severe Pain

HEALTH INFORMATION

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

DATE OF LAST MEDICAL CHECKUP: _____ BLOODWORK: _____

DO YOU *CURRENTLY* SUFFER FROM ANY DIAGNOSED MEDICAL CONDITIONS? Yes / No

____ Diabetes (Which type? _____)
____ Heart Condition (Specifically: _____)
____ Hypertension / Hypotension (Last Record: _____ mmHg)
____ Cancer (Specifically: _____)
____ Respiratory Condition (Specifically: _____)
____ Gastrointestinal Condition (Specifically: _____)
____ Reproductive Condition (Specifically: _____)
____ Nervous System Disorder (Specifically: _____)
____ Musculoskeletal Condition (Specifically: _____)
____ Skin Condition (Specifically: _____)

HOW LONG HAVE YOU HAD ANY OF THE CONDITIONS LISTED ABOVE? _____

ARE YOU CURRENTLY ON ANY MEDICATIONS (over-the-counter or prescribed)? Yes / No
IF YES, WHICH ONE(S)?

ARE YOU CURRENTLY TAKING ANY NATURAL SUPPLEMENTS/HERBAL REMEDIES? Yes / No
IF YES, WHICH ONE(S)?

ARE YOU A SMOKER? Yes / No HOW MANY YEARS? _____ # OF CIGARETTES/DAY? _____

ANY PROLONGED EXPOSURE TO SECOND-HAND SMOKE, CHEMICALS, OR TOXIC MATERIALS? Yes / No

DO YOU CONSUME ALCOHOL? Yes / No # OF ALCOHOLIC DRINKS PER WEEK? _____

DO YOU CONSUME CAFFEINE? Yes / No # OF CAFFEINATED DRINKS PER DAY? _____

DO YOU CONSUME ANY OTHER SUBSTANCES? IF YES, WHICH? _____

HAVE YOU HAD ANY SURGERY? IF YES, WHAT KIND & WHEN?

PLEASE LIST ALL MEDICAL CONDITIONS THAT APPEAR IN YOUR FAMILY HISTORY AND IN WHOM: _____

Please checkmark conditions that you currently have and any conditions you have had in the past.

Musculoskeletal

- Low back pain
- Pain between shoulders
- Neck pain
- Headaches
- Arm pain
- Leg pain
- Joint pain/stiffness
- Swelling
- Jaw pain/clicking
- Arthritis
- Osteoporosis

Nervous system

- Numbness in arm/hand
- Numbness in leg/foot
- Paralysis
- Dizziness
- Forgetfulness
- Anxiety
- Depression
- Fainting
- Convulsions

Cardiovascular / Respiratory

- Cold hands/feet
- Bruise easily
- Blood disorder
- Chest pain
- Shortness of breath
- High blood pressure
- Irregular heartbeat
- Heart problems
- Pneumonia
- Bronchitis
- Asthma
- Stroke

Eyes / Ears / Nose / Throat

- Vision problems
- Loss of smell
- Dental problems
- Sore throat
- Earache/infection
- Hearing loss
- Ringing in ears
- Sinus congestion

Gastro-Intestinal

- Poor appetite
- Excessive thirst
- Frequent nausea
- Diarrhea
- Constipation
- Bloating/Gas
- Abdominal cramps
- Heartburn
- Liver problems
- Bladder problems
- Kidney problems
- Painful/excess urination

Male / Female Reproductive

- Prostate problems
- Menstrual pain/cramps
- PMS
- Menstrual cycle irregularity
- Endometriosis
- Back pain with menstrual cycle

- Menopause
- Breast pain / lumps
- Fibroids / cysts
- Infertility
- Miscarriage
- Difficult delivery of baby

General

- Fatigue
- Irritability
- Allergies
- Poor sleep
- Poor balance
- Poor concentration
- High stress
- Weight loss
- Weight gain
- Fever
- Frequent colds

Other

IS THERE ANYTHING ELSE YOU WISH TO TELL US? _____

I HEREBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM DR. NEWSHA H. KASHANI OF ANY CHANGES IN MY HEALTH.

I AGREE TO ALLOW DR. NEWSHA H. KASHANI TO ASSESS ME FOR FURTHER EXAMINATION.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

DOCTOR'S SIGNATURE: _____