Patient Name: Time: Date: / /

INTAKE FORM

Full Legal Name:		Best Contact #: ( ) -	DOB: / /
Sex:	Address:	Occupation:	
Emergency Contact OR Guardian Name:	Relation:	Best Contact #: ( ) -	

MEDICAL HISTORY

	Self	Family		Self	Family		Self	Family
Addiction/Alcoholism	☐	☐	Diabetes	☐	☐	High Cholesterol	☐	☐
Asthma/Emphysema	☐	☐	Gallstones	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐	Thyroid Disorders	☐	☐
Dementia/Alzheimer's	☐	☐	High Blood Pressure	☐	☐	Hepatitis	☐	☐

Other Western Diagnosis:
Surgeries:
Hospitalizations/Traumas:
Medications & Why:
Allergies:

CHIEF COMPLAINT (must check one)

☐ Chronic Pain:__________________ ☐ Excess Weight ☐ Smoking Cessation ☐ Alcoholism / Substance Abuse

☐ A chiropractor's referral within the last 30 days for:

☐ Evaluated by a physician or dentist within 12 months for:

☐ None of the above, so I CANNOT be treated.

Start Date: Cause:

What makes it better: What makes it worse:

What treatment have you had for it:

GENERAL

Do you tend to be: ☐ Hot ☐ Cold ☐ Neutral ☐ Cold Hands/Feet	Night sweats: ☐ Often ☐ Sometimes ☐ Never
Do you sweat abnormally? Explain.	

DIET

Cravings: ☐ Carbs ☐ Sugar ☐ Salt ☐ Red Meat ☐ Chocolate ☐ Alcohol ☐ Tobacco ☐ Drugs ☐ Other:

Is there anything you do NOT eat?

URINATION + ELIMINATION

Urination: ☐ Frequent ☐ Scanty ☐ Profuse ☐ Burning ☐ Cloudy ☐ Difficulty ☐ Dribbling ☐ Dark ☐ Normal	
Bowel Movement: ☐ Brown ☐ Yellowish ☐ Green ☐ Black ☐ White ☐ Red ☐ Mucus	
☐ Loose ☐ Hard ☐ Alternating ☐ Formed ☐ Pellets ☐ Difficulty ☐ Gas ☐ Bloating ☐ Prolapse ☐ Incontinence	
Frequency of BM:	Other GI Issues:

ENERGY

Energy Level from 1 to 10:	Best/Worst Time of Day
Frequency of Exercise:	Type of Exercise:

Patient Name: Time: Date: / /

SLEEP

How many hours?	When do you sleep (from-until)?
□ Sleep Walking/Talking □ Vivid Dreams □ Trouble Falling Asleep □ Groggy □ Waking at Night	

EMOTIONS

Expressed most: □ "Depression" □ Anxiety □ Sadness □ Grief □ Joy □ Anger □ Fear □ Worry □ Other:

SYSTEMS REVIEW

Eyes	***Nose***	***Other***
□ Dry	□ Stuffy	□ Cough
□ Red	□ Runny	□ Sore Throat
□ Watery	□ Nose Bleeds	□ Dry Mouth /Throat
□ Itching	□ Post-Nasal Drip	□ Difficulty Breathing / Tight Chest
□ Burning	***Ears***	□ Nausea / Vomiting
□ Spots in Vision	□ Earache	□ Dizziness
□ Poor Night Vision	□ Hearing Loss	□ Skin Condition:_______________
□ Blurry OR Double Vision	□ Ringing (Hi/Low Pitch)	□ Dental: ______________________

HEADACHES

Frequency: | Locale: □ Temple □ Front □ Top □ Back of head □ Around the head □ Eyes

Pain: □ Sharp/stabbing □ Dull □ Throbbing □ Radiating □ Aching □ Light sensitivity □ Sound Sensitivity

FEMALE

Date of Last Menses: ___/___/___ | □ Post/Peri.-Menopausal | Color: □ Pale □ Dark □ Bright □ Dull

□ Clots □ Cramping □ Irritability □ Breast Distention □ Bloating □ Headache □ Spotting □ Light □ Heavy

Length of Cycle if NOT 28 days:	Age of First Menstruation:
# of Terminations:	Multiple Births (e.g. Twins):
# of Pregnancies:	Uterine Prolapse:
# of Births:	Fibroids:
# of Premature births:	Endometriosis:
Miscarriages:	Libido:
Date & Result of Last PAP:	Discharge:
Other:	

MALE

□ Erectile Dysfunction □ Discharge □ Low Libido □ Excessive Libido □ Other Issues:

Date & Result of Last Prostate Exam:

Besides body pain, is there anything else I should know? ____

____

I affirm that the above information is true, correct, and complete to the best of my knowledge. I agree to the financial obligations and privacy practices of the facility, and give my informed consent to treatment.

_______________________________ _______________________________

Patient Name (Printed) Guardian (if applicable)

_______________________________ _______________________________

Patient or Guardian Signature Date