Chiropractic New Patient Intake Form

1. Personal Information

- **Full Name:**
- **Date of Birth (MM/DD/YYYY):**
- **Gender:**
  - ☐ Male
  - ☐ Female
  - ☐ Other
- **Home Address:**
- **City: State: ZIP Code:**
- **Phone Number (Home):**
- **Phone Number (Cell):**
- **Email Address:**
- **Marital Status:**
  - ☐ Single
  - ☐ Married
  - ☐ Divorced
  - ☐ Widowed
- **Occupation:**
- **Employer:**
- **Emergency Contact Name:**
- **Emergency Contact Relationship:**
- **Emergency Contact Phone Number:**
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2. Health History

- **Primary Complaint/Reason for Visit:**
- **When did the symptoms begin?**
- **Have you received any treatment for this condition?**
  - ☐ Yes
  - ☐ No
  - If yes, what type of treatment?
- **Have you seen a chiropractor before?**
  - ☐ Yes
  - ☐ No

- **Rate your pain on a scale of 1-10 (10 being the worst):**
- **Describe the type of pain:**
  - ☐ Sharp
  - ☐ Dull
  - ☐ Burning
  - ☐ Throbbing
  - ☐ Aching
  - ☐ Other: ____________
- **Is the pain:**
  - ☐ Constant
  - ☐ Intermittent
- **What aggravates your pain?** (check all that apply)
  - ☐ Sitting
  - ☐ Standing
  - ☐ Walking
  - ☐ Lifting
  - ☐ Sleeping
  - ☐ Other: _____________
- **What relieves your pain?** (check all that apply)
  - ☐ Rest
  - ☐ Ice
  - ☐ Heat
  - ☐ Movement
  - ☐ Medication
  - ☐ Chiropractic Care
  - ☐ Other: ____________

3. Current Medications

- **Please list all current medications, including supplements and vitamins:**
  1. ____________________
  2. ____________________
  3. ____________________

4. Allergies

- **Do you have any allergies?**
  - ☐ Yes
  - ☐ No
  - If yes, please list: ________________

5. Past Medical History

- **Please check any conditions you currently have or have had in the past:**
  - ☐ High Blood Pressure

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Allergies
- ☐ Thyroid Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Digestive Issues
- ☐ Depression
- ☐ Anxiety
- ☐ Other: ___________________

6. Family Medical History

- **Please check any conditions that run in your family:**
  - ☐ High Blood Pressure
  - ☐ Heart Disease
  - ☐ Stroke
  - ☐ Cancer
  - ☐ Diabetes
  - ☐ Arthritis
  - ☐ Other: ____________________

7. Lifestyle Information

- **Do you exercise?**
  - ☐ Yes
  - ☐ No
  - If yes, how often and what type? ___________________
- **Do you smoke?**
  - ☐ Yes
  - ☐ No
  - If yes, how many per day? _______
- **Do you drink alcohol?**
  - ☐ Yes
  - ☐ No
  - If yes, how often? _____________
- **Do you have a healthy diet?**
  - ☐ Yes
  - ☐ No
  - If no, what are your dietary concerns? _______________

8. Sleep & Rest

- **How many hours of sleep do you get per night?**
  - ☐ Less than 4 hours
  - ☐ 4-6 hours
  - ☐ 6-8 hours
  - ☐ More than 8 hours
- **Do you have difficulty falling or staying asleep?**
  - ☐ Yes
  - ☐ No

9. Pain Diagram

- **Please mark the areas on the body where you feel pain:**
  - (Include a body diagram for patients to mark specific areas of discomfort)

10. Goals for Chiropractic Care

- **What are your goals for chiropractic treatment?**
  - ☐ Pain Relief
  - ☐ Improved Mobility
  - ☐ Improved Posture
  - ☐ Overall Wellness
  - ☐ Other: _____________________

11. Informed Consent

- I understand that the information I provide will be used by the chiropractor to assess my condition and develop a treatment plan. I consent to the chiropractic evaluation and treatment as recommended.
- **Signature:** ______________________________________
- **Date:** ____

12. Privacy Policy Acknowledgement

- I acknowledge that I have been provided with a copy of the clinic's privacy policies regarding the use and disclosure of my personal health information.
- **Signature:** ______________________________________
- **Date:** ____

Office Use Only

- **Blood Pressure:** _______ / _______
- **Height:** _______ ft/in **Weight:** _______ lbs
- **Date of Initial Consultation:** __________________
- **Notes:** ____