

Chiropractic Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

Contact Information:

Name _____ Occupation _____

Gender (circle) Male Female _____ Employer _____

Date of Birth _____ Work Phone # () _____

E-mail Address _____ Emergency Contact _____

Home Phone # () _____ Emergency Contact # () _____

Cell () _____ Contact Relationship _____

Home Address _____

YES NO Can we send you our seasonal newsletter and monthly calendar of events via email. Your email address will not be shared.

How did you hear about the Integrative Health Institute? (If another person, please provide name)

Care Co-ordination:

Medical Doctor _____ Specialist _____

Medical Doctor # () _____ Specialist # () _____

Medical Doctor Address _____ Specialist Address _____

Email _____ Email _____

Dentist _____ Specialist _____

Dentist # () _____ Specialist # () _____

Dentist Address _____ Specialist Address _____

Email _____ Email _____

Please List any other Medical Providers:

| Type of Medical Provider | Name | Phone # | Address |
|--------------------------|------|---------|---------|
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Chiropractic Intake Form

History of present concern:

What is the nature of your current concern and where do you feel the discomfort? _____

Have you had a similar symptom in the past? _____

How was this past symptom treated (circle one)? MD ND PT DC RMT Other: _____

Does the Pain Travel? Yes No

What is the nature of the pain (i.e. stabbing, dull, burning, pins and needles, aching, stiff & tight): _____

Does anything aggravate or relieve the pain?: _____

Does the pain wake you from your sleep?: Yes No

Is the pain worse in the morning?: Yes No Does the pain get better during the day?: Yes No

Does your work or daily activities interfere with the pain?: _____

Is there anything else that you think may be important?: _____

Medical History:

How would you describe your general state of health? (circle one) excellent good fair poor

Medications/Supplements: Please list all current medications/supplements

| Medication/Supplement | Dose (if known)/ Length of Use | Prescribing Physician | Condition it is treating |
|-----------------------|-----------------------------------|--------------------------|--------------------------|
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Review of Systems & Lifestyle:

Please indicate if any of the following relate to you:

| Condition | Circle One | Explanation |
|---------------------------|------------|-------------|
| Ear, nose throat concerns | Yes No | |
| Asthma or allergies | Yes No | |
| Neurological condition | Yes No | |
| Heart Disease | Yes No | |
| Cancer | Yes No | |
| Prostate problems (males) | Yes No | |
| Menstrual complaints | Yes No | |

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|-----------------------------|-----|----|--|
| Diabetes | Yes | No | |
| Arthritis | Yes | No | |
| Past motor vehicle accident | Yes | No | |
| Past sports injury | Yes | No | |
| Past surgeries | Yes | No | |
| Past broken bones | Yes | No | |
| Other | | | |

Please indicate if any of the following relate to you:

| Condition | Circle One | Explanation |
|--|-------------------------------------|-------------|
| Exercise Regularly | Yes No | How much? |
| Practice Yoga | Yes No | |
| Smoke | Yes No | |
| Consume more than 2 glasses of alcohol daily | Yes No | |
| How do you sleep | Back Side Stomach | |
| How old is your mattress? | | |
| How would you describe your pillow | Don't use Comfortable Uncomfortable | |

Additional Information

Please indicate where you are feeling discomfort. Provide as much detail as possible.

