CHIROPRACTIC INTAKE & HISTORY

WELLSPRING
CHIROPRACTIC LIFESTYLE CENTER
Experience the Fullness of Life

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE NAME
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Best Time/Way to Contact You _____
Sex ❑ M ❑ F Age _____ Birthday _____
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered
How many children do you have? _____
Are you currently pregnant? ❑ No ❑ Yes, I'm due _____
Would you like us to check on your insurance? ❑ No ❑ Yes

Employer / School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____

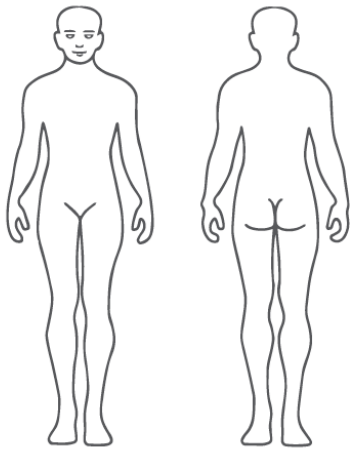
IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you?
_____
Children's health concerns? _____
Number of past pregnancies? _____
Insurance Company _____

HOW CAN WE HELP YOU?

What brings you in today? _____
_____
If you are already experiencing a symptom, what is it? _____
How bad is it? How intense are your symptoms? (circle one) ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿
NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check all that apply)
❑ Numbness ❑ Tingling ❑ Stiffness
❑ Dull ❑ Aching ❑ Sharp
❑ Cramping ❑ Nagging ❑ Shooting
❑ Burning ❑ Throbbing ❑ Stabbing
❑ Swelling ❑ Other _____
❑ Getting Better ❑ Getting Worse ❑ Not Changing
Aggravated by _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem. Circle those that are current

❑ Headaches	❑ Ringing in ears	❑ Diarrhea	❑ Fever	❑ Cold feet
❑ Dizziness	❑ Buzzing in ears	❑ Constipation	❑ Urinary issues	❑ Hot flashes
❑ Pins and needles in legs	❑ Fatigue	❑ Neck stiffness	❑ Fainting	❑ Heartburn
❑ Pins and needles in arms	❑ Sleeping Problems	❑ Back pain	❑ Loss of balance	❑ Ulcers
❑ Numbness in legs	❑ Cold sweats	❑ Menstrual pain	❑ Nervousness	❑ Tension
❑ Numbness in fingers	❑ Mood swings	❑ Menstrual irregularity	❑ Upset Stomach	
❑ Lose of smell	❑ Depression	❑ Loss of taste	❑ Other: _____	

HEALTH CONCERNS

Please list any other health concerns according to severity.	Rate of severity 1 = mild 10 = worst imaginable	When did this start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT		NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue? (circle one)

❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

❶ NOT COMMITED ❿ VERY COMMITED

HEALTH & ILLNESS HISTORY

Please check the box beside any conditions that you have now or have ever had. Circle those that are still current.

❑ AIDS/HIV	❑ Circulation Issues	❑ Headaches/Migraines	❑ Ringing in Ears
❑ Alcoholism	❑ Childhood Illness	❑ Heart Disease	❑ Scoliosis
❑ Anxiety	❑ Depression	❑ Hepatitis	❑ Shoulder Issues
❑ Arteriosclerosis	❑ Diabetes	❑ Hip Issues	❑ Stroke
❑ Arthritis	❑ Digestive Issues	❑ Immune Issues	❑ TMJ Issues
❑ Asthma/Allergies	❑ Elbow/Wrist/Hand Issues	❑ Lymphatic Issues	❑ Urinary Issues
❑ Back Pain	❑ Endocrine (Thyroid) Issues	❑ Multiple Sclerosis	❑ Osteoporosis
❑ Cardio Issues	❑ Foot/Ankle Issues	❑ Neck Pain	❑ Other _____
❑ Cancer	❑ Gout	❑ Reproductive Issues	

Have you had any surgeries, broken bones, auto accidents, or injuries? If so, when?

1. SURGERY / BROKEN BONE / ACCIDENT / INJURY _____ Date _____
2. SURGERY / BROKEN BONE / ACCIDENT / INJURY _____ Date _____
3. SURGERY / BROKEN BONE / ACCIDENT / INJURY _____ Date _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

STRESSORS

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, repetitive motions, hours sitting per day, etc.)
   a. _____
   b. _____
   c. _____

How is your current physical stress? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting better ❑ Getting worse

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, dehydration, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

How is your current bio-chemical stress? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting better ❑ Getting worse

3. Mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

How is your current mental/emotional stress? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting better ❑ Getting worse

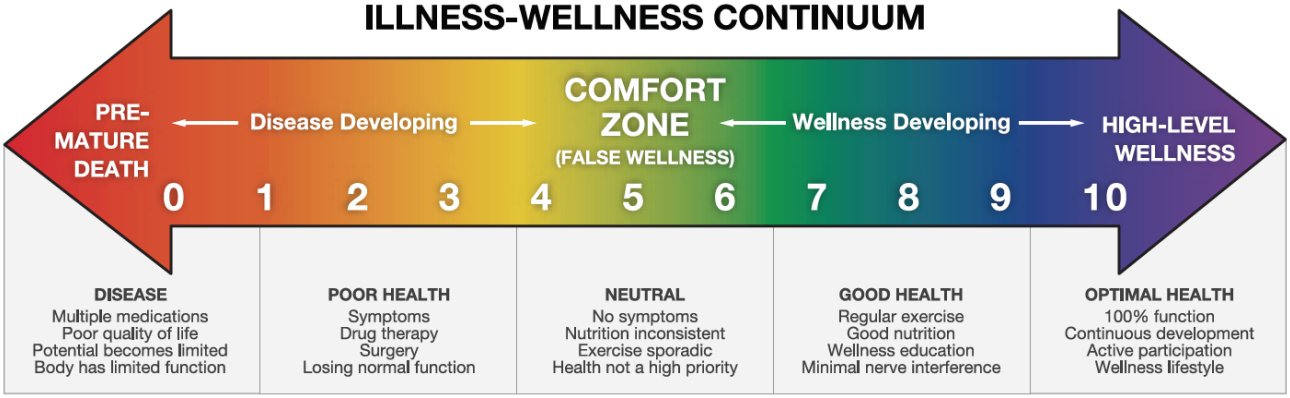
On a scale of 1-10 (1 being very poor and 10 being excellent), please grade your present levels of stress:

At work: _____ At home: _____ At play: _____

On a scale of 1-10 (1 being very poor and 10 being excellent), please describe your:

Eating habits: _____ Exercise: _____ Sleep: _____ General health: _____ Water consumption: _____ Stress level: _____

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are you health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

This office conforms to the current HIPPA information privacy guidelines. You may request a copy of our HIPPA policy at the front desk at any time. Please initial to indicate you have been made aware of its availability. _____

I consent to a professional and complete chiropractic examination and to any examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____