New Patient Chiropractic Intake

Tell us what brings you in and what you'd like to get back to doing.

Patient information

Name _____ Date of birth _____ Today's date _____

Phone _____ Email _____

Address _____ City _____ State _____ ZIP _____

Occupation _____ Who referred you? _____

Emergency contact _____ Relationship _____ Phone _____

What brings you in

Main concern and where you feel it (include any pain, numbness, or tingling that spreads)

When did it start? _____ How did it start, if known? _____

Was it related to an accident? ☐ No ☐ Yes Date _____ ☐ Auto ☐ Work ☐ Other _____

Pain now (0 = no pain, 10 = worst pain) ____ / 10 ☐ Constant ☐ Comes and goes

Symptoms ☐ Aching ☐ Sharp ☐ Burning ☐ Stiffness ☐ Numbness or tingling ☐ Other _____

Since it started, is it ☐ Better ☐ About the same ☐ Worse

What makes it worse? _____ What helps? _____

What have you tried so far, and how did it help? Include any tests or imaging, if applicable.

Daily life and goals

What does this problem make harder? Think about work, sleep, family life, or activities you enjoy.

What's one thing you'd like to get back to doing or do more comfortably?

Anything you're concerned about or that might make it hard to work toward that goal?

Health History

Patient name _____ Date _____

Medical conditions

Check any that apply now or in the past. Use the lines below for details or other conditions.

☐ Arthritis or rheumatoid arthritis ☐ Osteoporosis or low bone density ☐ Herniated disc

☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Stroke ☐ Bleeding disorder

☐ Cancer ☐ Thyroid disease ☐ Kidney disease ☐ Seizures ☐ Migraines ☐ None known

Are you pregnant or could you be? ☐ Yes ☐ No ☐ Unsure ☐ Not applicable Due date _____

Injuries and surgeries

List major injuries, fractures, surgeries, or implanted devices. Include approximate dates if known.

Medications and allergies

List current medications and supplements, including dose and how often you take them. You may attach a list.

Allergies and reactions ☐ None known

Activity and habits

Usual work or daily activity ☐ Mostly sitting ☐ Mostly standing ☐ Physical work ☐ Other _____

How often do you exercise? _____ Do you currently use tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, about how many drinks per week? _____

Anything else we should know