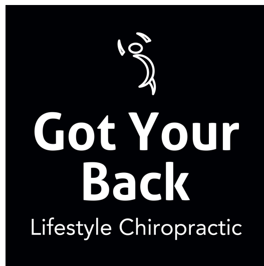


Got Your Back Lifestyle Chiropractic

NEW PATIENT INTAKE FORM

Name ________________________________ Preferred name ____________________

Address ____

City/State/Zip ____

Phone (home) ______________ (cell) ________________ (work) ____________________

Email address ____

Birth date ____________________________ Age_______________________________

Occupation____________________________ Employer___________________________

Children's names and ages ____

Emergency Contact: Name ____

Relationship __________________________ Phone______________________________

Favorite hobbies or interests ____

What Brings You Here?

Have you ever had chiropractic care before? ❑ No ❑ Yes

If yes, please tell us the doctor's name____

How did you find out about our office? ____

Are you receiving care from other health professionals? ❑ No ❑ Yes

If yes, please name them and their specialty______________________________________

____

Please list any drugs or medications you are taking_______________________________

____

____

Please list any vitamins/herbs/homeopathic/other you are taking ____________________

____

____

Are you pregnant? ❑ No ❑ Yes If yes, what month? ____________________

Health History

Do you have, or have you had, any of the following (please check all that apply).

❑ thyroid disease ❑ diabetes ❑ cancer ❑ depression ❑ anemia
❑ arthritis ❑ heart disease

If you have ever been diagnosed with another disease or condition, please describe:

____

Do you use ❑ coffee ❑ tea ❑ artificial sweeteners ❑ sugar
❑ alcohol ❑ cigarettes ❑ recreational drugs

Have you ever suffered from the following any of the following (please check all that apply).

❑ neck pain
❑ low back pain
❑ headache
❑ migraines
❑ arm pain/tingling
❑ shoulder pain
❑ hand pain/tingling
❑ leg pain/tingling
❑ jaw pain
❑ chest pain
❑ lung problems
❑ heart problems
❑ abnormal blood pressure
❑ irregular heartbeat
❑ ankle swelling
❑ cold extremities
❑ blurred vision
❑ vision problems
❑ difficulty breathing
❑ stuffy nose
❑ allergies
❑ fainting
❑ weight loss
❑ poor appetite
❑ excessive appetite
❑ nervousness
❑ confusion
❑ depression
❑ dental problems
❑ excessive thirst
❑ frequent nausea
❑ vomiting
❑ prostate problem
❑ breast pain/lump
❑ cramps
❑ painful urination
❑ bladder trouble
❑ excessive urination
❑ discolored urine
❑ gas/bloating after meals
❑ heartburn
❑ colitis
❑ irritable bowel
❑ black or bloody stools
❑ constipation
❑ hemorrhoids
❑ liver problems
❑ stroke
❑ paralysis
❑ tingling
❑ numbness
❑ fatigue
❑ dizziness
❑ loss of sleep
❑ difficulty hearing
❑ ear pain

If applicable, date of last menstrual period ______________________

Past injuries can affect present health (please check all that apply).

❑ falls/accidents
❑ sports injuries
❑ spinal tap
❑ use(d) cane or walker
❑ knocked unconscious
❑ head injuries
❑ broken bones
❑ surgery
❑ extensive dental work
❑ fights
❑ dislocations
❑ traction
❑ dental appliances

If yes to any of the above, please describe ______________________________

____

____

Current Health

What are your most pressing health concerns? ____________________

____

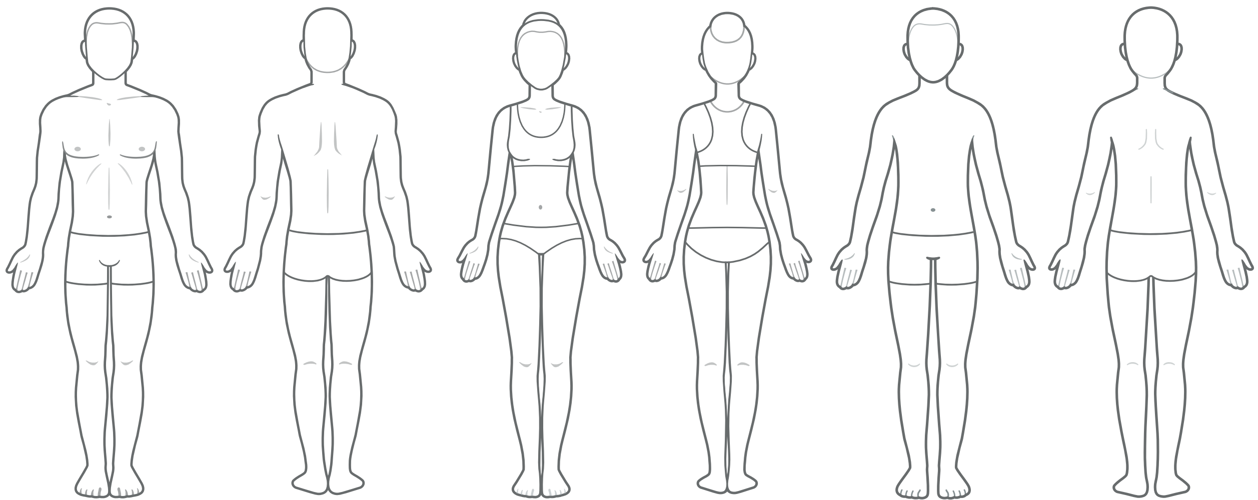
____

Is it ❑ getting worse ❑ improving ❑ intermittent
❑ constant ❑ can't say

For how long? ____________________

____

Where is the problem? Please use the illustrations and lines below to explain.



Front ____________________

____

Back ____________________

____

Do you have ❑ pain ❑ numbness ❑ tingling ❑ aches

Is your pain ❑ sharp ❑ dull ❑ throbbing ❑ constant ❑ intermittent

Are your symptoms affected by ❑ sitting ❑ standing ❑ walking
❑ bending ❑ lying down ❑ weather

Are there other health concerns or anything else you'd like us to know about you?

If yes, please tell us ____________________

____

____