# Patient Intake Form

**Patients Name** _____ **Date** _____

**Main complain:** _____

1. **Is this visit due to an injury?** ☐ Yes ☐ No
   If yes, is the injury related to:
   ☐ Job
   ☐ Auto Accident
   ☐ Personal Injury
   ☐ Other _____
   Date of Accident _____
2. **Have you had this problem before?** ☐ Yes ☐ No - if yes when: _____
3. **Have you had previous Chiropractic Care?** ☐ Yes ☐ No - if yes when: _____
4. **Did you see your Primary Care Physician for this condition?** ☐ Yes Outcome: _____
   ☐ No _____
5. **For *this* condition have you had:**

| | | |
|---|---|---|
| **X-rays** | ☐ Yes | ☐ No |
| **CT Scan** | ☐ Yes | ☐ No |
| **MRI** | ☐ Yes | ☐ No |
| **Physical Therapy** | ☐ Yes | ☐ No |
| **Over the counter or presciption medications** | ☐ Yes | ☐ No- if yes list _____ |

6. **Do you have any of the following medical conditions?**
   ☐ Arthritis ☐ Hypertension
   ☐ Cancer ☐ Thyroid
   ☐ Diabetes ☐ Heart Disease
   ☐ HIV
   ☐ Other _____
7. **Family health history (parents or siblings)**

| | **Disease** | **Family Member** |
|---|---|---|
| ☐ | Arthritis | _____ |
| ☐ | Cancer | _____ |
| ☐ | Diabetes | _____ |
| ☐ | Heart Disease | _____ |

8. **Social History**
   Smoking ☐ None ☐ Packs/Week

   *Drinking*

| | | | | |
|---|---|---|---|---|
| Alcohol | ☐ None | ☐ Light | ☐ Moderate | ☐ Heavy |
| Caffiene | ☐ None | ☐ Light | ☐ Moderate | ☐ Heavy |
| Water | ☐ None | ☐ Light | ☐ Moderate | ☐ Heavy |

9. **List Current Medications** _____
10. **List Any Allergies** _____
11. **List Surgeries/Hospitalizations**

| **Surgery/Hospitalizations** | **Aprox. Date** |
|---|---|
| | |
| | |
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| | |

Scanned: