HEALTH + WELLNESS

equilibrium

Chiropractic Intake Form

How did you hear about us? ☐ Family/Friend ☐ Doctor Referral ☐ Internet ☐ Insurance ☐ Social Media ☐ ZocDoc

PERSONAL INFORMATION

Name: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

PRIMARY PHONE to receive a call or message from the doctor: (_____) _____-_____

Email Address: _____

EMERGENCY CONTACT

Name: _____ Contact number for this person: (_____) _____-_____

MAIN COMPLAINT

_____

HISTORY OF THIS CONDITION

When did this condition BEGIN? _____ Has this happened before? ☐ YES ☐ NO

If YES, how many times? _____ When was the last episode? _____

Describe progression of problem since it started:

☐ started to get better, but plateaued ☐ constantly getting worse ☐ same since starting ☐ got better initially, but now is worse

How did it start? _____

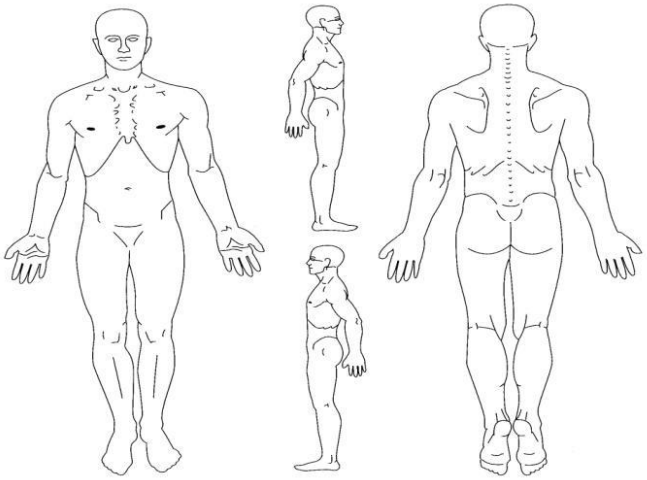
If because of an accident, date of accident: _____

Did condition/pain start due to the accident? ☐ Yes ☐ No

If no, when did the condition/pain start? _____

Indicate the location and type of your sensations PRESENTLY.

A = Ache B = Burning N = Numbness P = Pins/Needles S = Stabbing

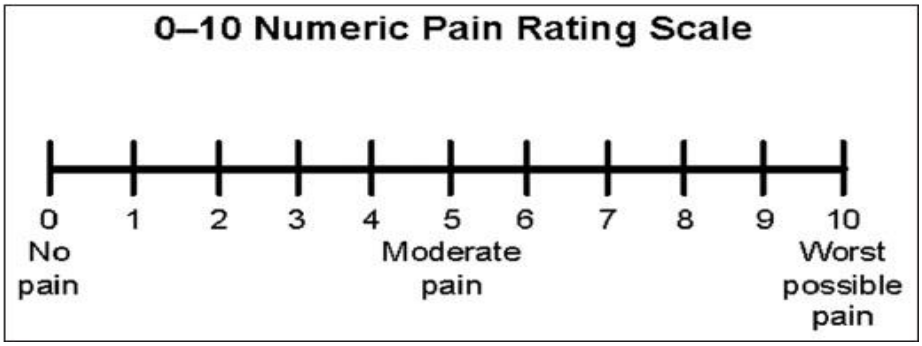


Do you have ANY OTHER CONDITIONS or SYMPTOMS?

_____

_____

Place an X on the line below to show the amount of pain you are currently feeling.



REVIEW OF SYSTEMS

Eyes/Vision ☐ ***I DENY having or have had any of the symptoms or problems listed below***

☐ blindness ☐ change in vision ☐ photophobia ☐ blurred vision ☐ wear glasses/contacts
☐ double vision ☐ glaucoma ☐ cataracts ☐ eye pain

Ears, Nose, and Throat ☐ ***I DENY having or have had any of the symptoms or problems listed below***

☐ nose bleeds ☐ hearing loss ☐ nosebleeds ☐ rhinorrhea (runny nose) ☐ ear pain
☐ history of head injury ☐ tinnitus ☐ dizziness ☐ loss of sense of smell ☐ headaches
☐ fainting ☐ difficulty swallowing ☐ snoring ☐ TMJ problems ☐ nasal congestion

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Respiration ☐ ***I DENY having or have had any of the symptoms or problems listed below***

☐ asthma ☐ coughing up blood ☐ cough ☐ shortness of breath ☐ wheezing

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Cardiovascular ☐ ***I DENY having or have had any of the symptoms or problems listed below***

☐ high blood pressure ☐ varicose veins ☐ orthopnea (difficulty breathing lying down)
☐ heart problems ☐ low blood pressure ☐ claudication (leg pain/ache)
☐ chest pain ☐ swelling of legs ☐ shortness of breath with exertion or exercise

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Gastrointestinal ☐ ***I DENY having or have had any of the symptoms or problems listed below***

☐ abdominal pain ☐ indigestion ☐ black - tarry stools ☐ heartburn
☐ belching ☐ difficulty swallowing ☐ diarrhea ☐ nausea
☐ constipation ☐ hemorrhoids ☐ ulcers

Female ☐ ***I DENY having or have had any of the symptoms or problems listed below***

☐ birth control ☐ menstrual cramps ☐ pregnancy
☐ breast lumps/pain ☐ frequent urination *How many?* _____
☐ hormone therapy ☐ irregular menstruation *When?* _____

History of psychological issues *(please list)*

_____

_____

List any surgeries | procedures & dates

_____

_____

_____

PREVIOUS MEDICAL CARE

Previous care FOR SAME CONDITION ☐ ***I DENY having seen a doctor for THIS condition***

Practitioner's name: _____

What type of treatment? ☐ Chiropractic ☐ Medical ☐ Acupuncture

Did the treatment resolve the condition? ☐ Yes ☐ No - Explain: _____

Date of Last Chiropractic Session: _____

Date of Last Medical Session: _____

Date of Last Acupuncture Session: _____

CURRENT MEDICATIONS/SUPPLEMENTS

Medication/Supplement	Dosage	For what condition?	How long have you been taking this?

The information on this form is correct and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____