THE CONNECT CHIROPRACTIC

INTAKE FORM

ABOUT THE PATIENT

Name: ______ Today's Date: ______ Birth date: ______ Age: ______
Address: ______ City: ______ State: ______ Zip: ______
Home Phone: ______ Cell Phone: ______ Work Phone: ______ Gender: ______
Significant Other's Name: ______
Kid's Names and Ages: ______
Your Employer: ______ Type of Work: ______
E-Mail Address: ______ Have you been to a chiropractor before? ☐ No ☐ Yes
Emergency Contact: ______ Phone Number: ______
Name of Medical Doctor(s): ______
Referred by: ______

PATIENT CONDITION

Chief Complaint: ______
When did symptoms start? ______
How did symptoms start? ______
What makes it better? ______
What makes it worse? ______
How much of the day do you feel symptoms? ______
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Are the symptoms getting:
☐ Worse ☐ Better ☐ Staying the Same
Have you had anything like this before? ☐ No ☐ Yes
Describe your symptoms (check all that apply):
☐ Dull Ache ☐ Numb ☐ Throbbing ☐ Tightness
☐ Burning ☐ Tingling ☐ Stabbing ☐ Shooting
☐ Sharp ☐ Radiating. If Radiates, to where?: ______
Please rate the intensity of your symptoms from 0-10 with 10 being the worse possible:
0 1 2 3 4 5 6 7 8 9 10
Please select symptom intensity:
☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable
What have you tried that makes the symptoms better?:
☐ Medication ☐ Chiropractic ☐ Physical Therapy
☐ Massage Therapy ☐ Surgery ☐ Acupuncture
☐ Other: ______
What activities does this interfere with? (check all that apply):
☐ Prolonged sitting ☐ Walking ☐ Prolonged standing
☐ Sleeping ☐ Bending ☐ Social/Recreational activities
☐ Lifting ☐ Personal care (washing, dressing, etc.)
☐ Traveling ☐ Other: ______

ADDITIONAL CONDITIONS (IF APPLICABLE)

Additional Complaint: ______
When did symptoms start? ______
How did symptoms start? ______
What makes it better? ______
What makes it worse? ______
How much of the day do you feel symptoms? ______
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Are the symptoms getting:
☐ Worse ☐ Better ☐ Staying the Same
Have you had anything like this before? ☐ No ☐ Yes
Describe your symptoms (check all that apply):
☐ Dull Ache ☐ Numb ☐ Throbbing ☐ Tightness
☐ Burning ☐ Tingling ☐ Stabbing ☐ Shooting
☐ Sharp ☐ Radiating. If Radiates, to where?: ______
Please rate the intensity of your symptoms from 0-10 with 10 being the worse possible:
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What have you tried that makes the symptoms better?:
☐ Medication ☐ Chiropractic ☐ Physical Therapy
☐ Massage Therapy ☐ Surgery ☐ Acupuncture
☐ Other: ______
What activities does this interfere with? (check all that apply):
☐ Prolonged sitting ☐ Walking ☐ Prolonged standing
☐ Sleeping ☐ Bending ☐ Social/Recreational activities
☐ Lifting ☐ Personal care (washing, dressing, etc.)
☐ Traveling ☐ Other: ______

Are you pregnant? ❑ No ❑ Yes If yes, Due Date: ______

PREVIOUS INJURY AND TREATMENT HISTORY

1. List any past auto collisions: ______ Was any care received? ______
2. List any past work injuries: ______ Was any care received? ______
3. List any past sport, recreational, or home injuries: ______
4. Please describe any past conditions and treatment received: ______
5. Please list any past hospitalizations and surgeries: ______

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GENERAL HEALTH HISTORY

Past	Present	
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Shortness of Breath
☐	☐	Allergies/Asthma
☐	☐	Medication Side Effects
☐	☐	Diabetes
☐	☐	Hands or Feet cold
☐	☐	Muscle aches
☐	☐	Trouble Walking
☐	☐	Leg/Foot Numbness
☐	☐	Fainting
☐	☐	Gall Bladder Trouble
☐	☐	Ringing in Ears
☐	☐	Ear Problems
☐	☐	Sleeping Problems
☐	☐	Vision Problems
☐	☐	Thyroid Problems
☐	☐	Liver Disease
☐	☐	Kidney Problems
☐	☐	Other

Past	Present	
☐	☐	Light Bothers Eyes
☐	☐	Urinary Problems
☐	☐	Easy Bruising
☐	☐	Tobacco Use
☐	☐	Dental Problems
☐	☐	Fibromyalgia
☐	☐	Blood Thinner use
☐	☐	HIV Positive
☐	☐	Cancer Depression
☐	☐	Alcohol Use
☐	☐	High or Stroke History
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Digestive Problems
☐	☐	Pain all Over Tension /
☐	☐	Irritability Chest Pains
☐	☐	TMJ
☐	☐	Heart Pacemaker
☐	☐	Heart Problems

1. List any medications you are taking: ____

____

2. Please list all doctors you are currently seeing: ____

____

____

FAMILY HISTORY

Father's side: ☐Heart Disease ☐Cancer ☐Diabetes ☐Heavy Medication use ☐ Arthritis ☐Other:____________________

Mother's side: ☐Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐Arthritis ☐Other:____________________

Is there any other family history you want us to know?____

____

AUTHORIZATION AND CONSENT

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Limitless Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

____

Patient / Parent (This represents a long term authorization for all occasions of service) Date

____

Doctor's Signature Date