

Patient Intake Overview

As a whole health Chiropractic office, DEC concentrates on creating a truly balanced foundation for health and strives to address the issues that have brought you to our office while helping you to achieve improved health potential. Daily, we experience chemical, physical, and emotional stressors that accumulate within our bodies. The effects of such life stressors can range from little or no symptoms to serious illness. By building a strong foundation through optimal function of your spine and nervous system, your body will have a much greater ability to handle daily stressors and increase your potential for wellness.

Name: _____ Age: _____ Today's Date: _____

Address: _____

Phone Numbers: Home _____ Cell _____ Email _____

Birthdate: _____ Male: _____ Female: _____ SS#: _____

Occupation: _____ Employer: _____

Marital Status: S _____ M _____ D _____ W _____ Partnered _____

Significant Other's Occupation _____ Number of Children: _____ Ages of Children: _____

How did you hear about our office? _____

Purpose and Goals

Please answer the following questions so that we can best help you achieve your healthcare goals.

- › What is the purpose of your visit and your overall healthcare goal(s)?

- › If a particular injury or condition has brought you here, when did it first develop?

- › If there is pain associated with your injury or condition, please circle the number that best describes its intensity level using a scale of 1-10, 1 being the lowest level of intensity.

1 2 3 4 5 6 7 8 9 10

Please answer the following question by circling the word(s) below that most accurately apply.

- › Has the pain been getting: **Worse** **Better** **Staying same**
- › Is the pain: **Sharp** **Dull** **Constant** **Intermittent**
- › Does the pain interfere with your: **Work** **Sitting** **Standing** **Walking** **Sleep** **Daily Activities**
- › What makes it worse? _____

Tell Us About Your Health

Childhood up to age 17 (Please indicate Yes or No)

<u>Questions</u>	<u>Yes</u>	<u>No</u>	<u>Questions</u>	<u>Yes</u>	<u>No</u>
Did you have any childhood illnesses?	_____	_____	Have you taken antibiotics or used inhalers for prolonged periods?	_____	_____
Did you play sports?	_____	_____	Other traumas?	_____	_____
Did you use recreational drugs?	_____	_____	Did you receive childhood vaccinations?	_____	_____
Did you have any surgeries?	_____	_____	Did you receive regular Chiropractic care?	_____	_____
Have you been in any car accidents?	_____	_____			
Anything else you think we should know?	_____				

Adulthood

- › Do you smoke? Y/N _____ How Long? _____
- › Do you drink alcohol? Y/N _____
- › Any accidents or injuries? Y/N _____
- › Do you play adult sports? Y/N _____
- › Do you participate in extreme sports? Y/N _____
- › On a scale of 1 - 10 rate your stress level:
 (1= none / 10 = extreme) personal stress: _____ occupational stress: _____
- › Please rate the following using Excellent, Good and Poor to describe the following:
 Diet: _____ Exercise: _____ Sleep: _____ Overall Health: _____

Please mark the items below if you have EVER experienced any of the following:

_____ Neck Issues	_____ Mood Swings	_____ Allergies
_____ Shoulder Issues	_____ Balance Issues	_____ Hay Fever
_____ Arm Issues	_____ Broken Bones	_____ Asthma
_____ Numbness in Hands	_____ Muscle Cramps	_____ Nervousness
_____ Pain between Shoulder	_____ Weak Muscles	_____ Tension
_____ Leg Pain	_____ Fainting	_____ Ulcers
_____ Numbness/Tingling in Legs	_____ Forgetfulness	_____ Heart Burn
_____ Cold Hands/Feet	_____ Anxiety/Depression	_____ Fever
_____ Numbness/Tingling in Arms	_____ Vision Problems	_____ Kidney Infection
_____ Stiff Joints	_____ Ringing Ears	_____ Menstrual Issues
_____ Painful Joints	_____ Ear Infections	_____ Diarrhea
_____ Sleeping Issues	_____ Hearing Loss	_____ Constipation
_____ Headaches	_____ Fatigue	_____ Frequent Colds

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Please list the medications or supplements that you are currently taking.

Medications/Supplements	Daily Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any other members of your **Healthcare Team** that may also be helping you address your wellness or this particular condition.

Physician/Practitioner	Contact Info (Address and/or phone number)
_____	_____
_____	_____
_____	_____
_____	_____

Family Health Profile

In addition to your health, we are also interested in the health and well being of your loved ones. Please list any of their current health concerns below (i.e., high cholesterol, sports injuries, lack of mobility, financial stress, etc.):

Spouse/Partner:	_____
Children:	_____
Parents:	_____
Siblings:	_____
Close Friends:	_____

I agree that I have answered all questions on this form to the best of my knowledge and allow the DEC physicians and practitioners to examine me and help me achieve optimal health.

Signature

Date