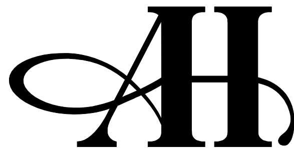


Aligned Health

CHIROPRACTIC PATIENT INTAKE FORM

Welcome !

We at Aligned Health Chiropractic and Wellness want to provide you with the best possible care. To assist us, please complete the following patient information. **All information contained within this form is strictly confidential and is only used to better understand your health issues and ensure delivery of the best and most appropriate treatment.**

Patient Information :

Patient Name: ___________________________ Date:__________ Age: ________ DOB: _____________

Name I prefer to be known as in office: ______________________ SSN (optional): ______________________

Mailing Address: ____ Sex: Male ◻ Female ◻ Pregnant ◻

Street Address:____ Home phone: ( )________________

City: ________________________ State: ________ Zip: _______ E-mail address: _____________________

Occupation: ____ Marital status: M ◻ D ◻ S ◻ W ◻

Employer: ____ Children: Y ◻ N ◻ How many? _____

Length of time employed: __________________________________ Work phone: ( ) _______________

Emergency contact name and phone number: __________________________________ ( )_____________

Primary healthcare clinic: _________________________________ Clinic Location: _____________________

Primary physician: ____ Date of MD visit: ____________________

How did you hear about our office? Newspaper ◻ Yellow Pages ◻ Word of Mouth ◻ Referral ◻

Whom may we thank for referring you? ____

Have you ever visited a chiropractor before? ◻ No ◻ Yes When? _____________ Dr: _________________

Initial Visit Information : Please complete in as much detail as possible .

Purpose of today's visit: ____

Prior episodes? ____

Associated Symptoms: ____

Is this the result of : ◻ Accident/Injury ◻ Worsening long-term problem ◻Not sure ◻ Wellness

How do you believe this issue started? ____

____

How long have you had the condition? ___________________________ Is it worsening? Yes ◻ No ◻

What positions or activities aggravate the condition? ____

What positions or activities alleviate the condition? ____

How is this complaint interfering with work? ____

How is this complaint interfering with sleep? ____

How is this complaint interfering with recreational activities? ____

How is this complaint interfering with other responsibilities? ____

Does it hurt to: cough ◻ sneeze ◻ bend over ◻ lift ◻ push ◻ pull ◻

Have you been treated by any providers for this issue? Yes ◻ No ◻ Was a diagnosis made? Yes ◻ No ◻

Name of provider and location: ____

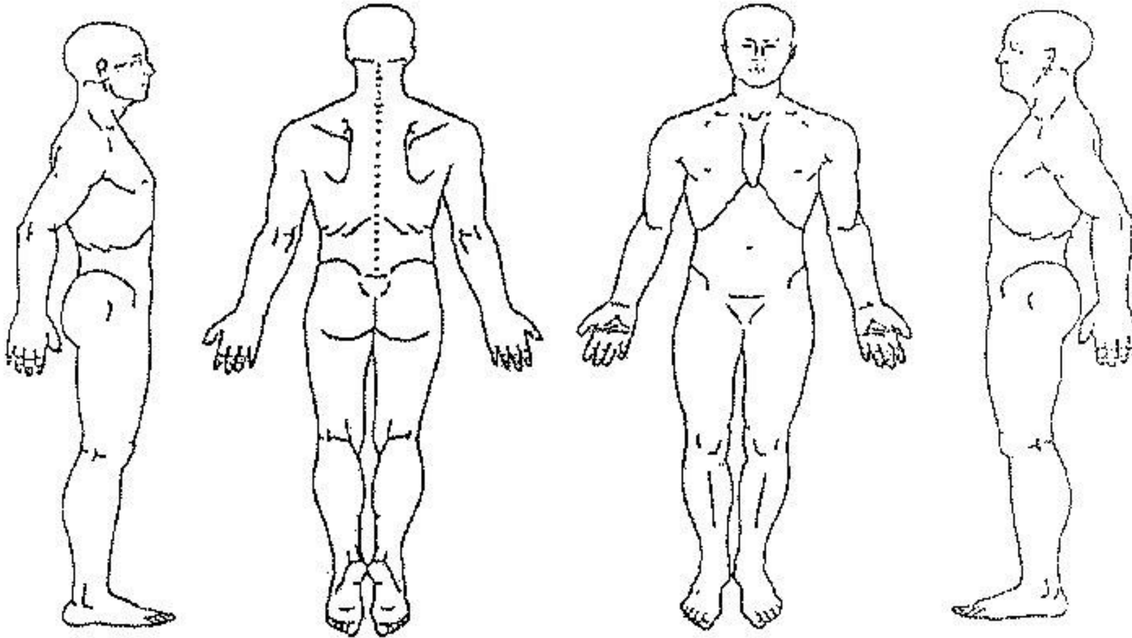
Diagnosis: ____ Length of time under care: _____________

What were the results of treatment? ____

Are you presently taking any pain medications for your complaint? Yes ◻ No ◻ If yes, list: ____________________

Have you tried ice ◻ or heat ◻ for your complaint? Yes ◻ No ◻ If yes, was it helpful? Yes ◻ No ◻

Have you tried anything else to relieve your discomfort? Prescription medication ☐ OTC drugs ☐ Physical Therapy ☐
Massage ☐ Chiropractic ☐ Other, specify: ____
Does your discomfort radiate into the legs or the arms? Yes ☐ No ☐ Specify: ___________________________________
Is your discomfort: Constant ☐ Comes and goes ☐ How often? ______________________ ________________
____
Any prior relevant injuries? If so, list: ____
____
How extreme are your current symptoms? No pain 0 o-o-o-o-o-o-o-o-o-o-10 agonizing
Please mark your areas of pain on the figures below.



Please check the boxes that correspond to your complaint:
Tingling ☐ Stabbing ☐ Sharp ☐ Dull ☐ Tense ☐ Throbbing ☐ Weak ☐ Burning ☐ Numb ☐ Achy ☐ Shooting ☐
Are you presently taking any medications or supplements? Yes ☐ No ☐ Please list. ______________________________
____
____
Do you have any allergies? Yes ☐ No ☐ Name them: ____
Have you been treated for any health condition in the last year? Yes ☐ No ☐ If yes, list: _________________________
____

Past Health History: *List factors that may have an impact on your current complaint.*

Have you been in any accidents in the past, even as a child? (Fall down stairs or ladder, auto, horse, etc)
Please list: ____ Date: ____________________
____ Date: ____________________
____ Date: ____________________
Have you ever broken any bones? Yes ☐ No ☐ List: ____

Previous surgeries	Date of surgery
☐ Appendectomy	___________________________
☐ Bypass surgery	___________________________
☐ Cancer	___________________________
☐ Eye surgery	___________________________
☐ Hysterectomy	___________________________
☐ Pacemaker	___________________________
☐ Other	___________________________

Please check if you are currently taking or have taken.		
☐ Antibiotics	☐ Past	☐ Present
☐ Birth Control Pills	☐ Past	☐ Present
☐ Chemotherapy	☐ Past	☐ Present
☐ Hormone Replacement	☐ Past	☐ Present

Social / Family History: *List the dietary and lifestyle factors that may affect recovery.*

My diet is: Good □ Fair □ Poor □ I feel that my health is: Good □ Fair □ Poor □

Describe your typical eating habits: □ Skip breakfast □ 2 meals/day □ 3 meals/day □ Snack between meals

Please indicate the frequency of the following habits using N: none, L: light, M: moderate, H: heavy.

Alcohol use:____ Coffee:____ Tobacco:____ Exercise:____ Soft drinks:____ Water:____ Sugar:____

Smokers: How many packs per day do you smoke? ________ How many years have you smoked? _____

Please rate your stress level on a scale from 1-10, 1 being none, 10 being extreme: __________________

How many hours of sleep do you get per night? ___________

Do you have a family history of: □ heart disease □ thyroid issues □ cancer □ diabetes

Do any other hereditary issues apply to you? Please list: ____

Please check if any of the following apply to you: **These answers may determine the method of treatment.**

Musculoskeletal	Skin/ Reproductive	Nervous System
□ Headaches	□ Rashes	□ Numbness/tingling
□ Joint stiffness/swelling	□ Boils	□ Twitching of face
□ Spasms/cramps	□ Eczema/Psoriasis	□ Fatigue
□ Broken/fractured bones	□ Allergies	□ Chronic pain
□ Strains/sprains	□ Athlete's Foot	□ Sleep disorders
□ Back, hip pain	□ Warts	□ Ulcers
□ Shoulder, neck, arm, hand pain	□ Moles	□ Paralysis
□ Leg, foot pain	□ Acne	□ Herpes/shingles
□ Chest, ribs, abdominal pain	□ Cosmetic surgery	□ Cerebral Palsy
□ Problems walking	□ Pregnancy	□ Epilepsy
□ Jaw pain/TMJ	□ PMS	□ Chronic Fatigue Syndrome
□ Tendinitis	□ Menopause	□ Multiple Sclerosis
□ Bursitis	□ Pelvic Inflammatory Disease	□ Muscular Dystrophy
□ Arthritis	□ Endometriosis	□ Parkinson's disease
□ Osteoporosis	□ Hysterectomy	□ Spinal cord injury
□ Scoliosis	□ Fertility concerns	□ Other: ___________________
□ Bone or joint disease	□ Prostate problems	
□ Other: __________________	□ Other: ____________________	

Circulatory/ Respiratory	Digestive System	Other
□ Dizziness	□ Nervous stomach	□ Loss of appetite
□ Shortness of breath	□ Indigestion	□ Forgetfulness
□ Fainting	□ Constipation	□ Confusion
□ Cold feet or hands	□ Intestinal gas/bloating	□ Depression
□ Cold sweats	□ Diarrhea	□ Difficulty concentrating
□ Swollen ankles	□ Diverticulitis	□ Hearing impaired
□ Pressure sores	□ Irritable bowel syndrome	□ Visually impaired
□ Varicose veins	□ Crohn's Disease	□ Burning upon urination
□ Blood clots	□ Colitis	□ Bladder infection
□ Stroke	□ Adaptive aids	□ Eating disorder
□ Heart condition	□ Other: ___________________	□ Diabetes
□ Allergies		□ Fibromyalgia
□ Sinus problems		□ Post/Polio Syndrome
□ Asthma		□ Cancer
□ High blood pressure		□ Infectious disease (please list) __________________________
□ Low blood pressure		□ Other congenital or acquired disabilities ____________________________
□ Lymphedema		
□ Other: ___________________		