IRON MOUNTAIN CHIROPRACTIC

Patient Intake Information

CONFIDENTIAL HEALTH INFORMATION

Date _____

(Legal) First Name (Legal) MI (Legal) Last Name Date of Birth Age

Street _____ Apt. _____

City_____ State _____ Zip _____ Gender: [ ] M [ ] F

Social Security #:_____ Marital Status: [ ] S [ ] M [ ] W [ ] D Spouse: _____

Occupation: _____ Employer: _____

Contact Info: Home Ph: _____ Cell Ph: _____ Work Ph: _____

Cell Carrier: _____ Home Email:_____ Work Email:_____

Contact Preference ____Home Ph ____Work Ph ____Cell Ph ____Email Hm ____Email Wk ____Postal Mail

Emergency Contact:_____ Relation:_____ Phone: _____

Who referred you to our office?_____ Phone: _____

Have you ever been treated by a chiropractor? [ ] Y [ ] N If so, when was your last treatment?_____

PATIENT HISTORY

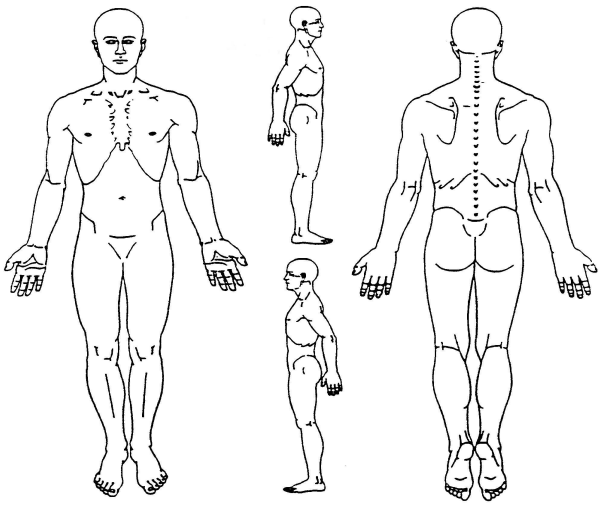
- **Please give a brief description of the problem[s] you are experiencing**:

1._____

2._____

- **When did the problem[s] start?** 1. _____ 2. _____

- **Where are your symptoms?**



- **What appears to be the initial cause?**

1._____

2._____

- **What does the pain feel like? (Circle all that apply)**

-achy -burning -dull -sharp -stiffness -throbbing

-cramps -nagging -numb -shooting -stabbing -tingling

- **Pain level (*0 = no pain, 10 = worst pain ever felt*):**

currently_____ worst_____ best_____

- **Any pain, numbness, tingling in arms/legs?** [ ] Y [ ] N

What part of the day is it worse? _____ What increases symptoms? _____

What part of the day is it better? _____ What decreases symptoms?_____

PAST HISTORY

● Musculoskeletal Conditions (please check all that apply)

[ ] Headaches/Migraines	[ ] Hip Pain/Discomfort	[ ] Arthritis
[ ] Neck Pain/Discomfort	[ ] Sciatica	[ ] Fused/Fixated Joints
[ ] Shoulder Pain/Discomfort	[ ] Elbow Pain/Discomfort	[ ] Herniated Disc
[ ] Upper Back Pain/Discomfort	[ ] Wrist Pain/Discomfort	[ ] Joint Replacement
[ ] Middle Back Pain/Discomfort	[ ] Knee Pain/Discomfort	[ ] Osteoporosis
[ ] Low Back Pain/Discomfort	[ ] Ankle Pain/Discomfort	[ ] Osteopenia

[ ] Inflammation/Swelling; where_____

● Other Conditions

[ ] Cancer	[ ] Heart Disease	[ ] Tumors	[ ] AIDS/HIV
[ ] Stroke	[ ] Diabetes	[ ] Seizures	[ ] Hepatitis
[ ] High Blood Pressure	[ ] High Cholesterol	[ ] Tuberculosis	[ ] Pacemaker
[ ] Hernia	[ ] Allergies	[ ] Other_____	

● Indicate if you have experienced any of the following and mark how recently

Surgeries	[ ] Yes	[ ] No	--------	[ ] Less than 1 month	[ ] 1-6 months	[ ] More than 12 months
Falls/Accidents	[ ] Yes	[ ] No	--------	[ ] Less than 1 month	[ ] 1-6 months	[ ] More than 12 months
Hospitalizations	[ ] Yes	[ ] No	--------	[ ] Less than 1 month	[ ] 1-6 months	[ ] More than 12 months

If yes to any, list and describe _____

● Indicate if you use any of the following

Alcohol	[ ] Yes	[ ] No	Daily Amount _____
Coffee	[ ] Yes	[ ] No	Daily Amount _____
Tobacco	[ ] Yes	[ ] No	Daily Amount _____
Drugs	[ ] Yes	[ ] No	Daily Amount _____
Soda	[ ] Yes	[ ] No	Daily Amount _____

● Daily Activities

Exercise Frequency _____
Water intake per day _____
Average sleep per night _____

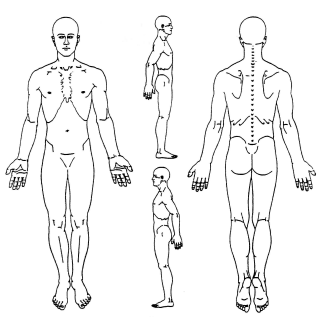
● Please list all medications and supplements that you are currently taking

_____

_____

OFFICE USE ONLY Dr. initials _____

POSTURE



ROM	Csp	Tsp	LB
Flex			
Ext			
Lrot			
Rrot			
LLF			
RLF			

MRS

Upper Extremities

Lower Extremities

ORTHOS

Jacks

Dist

Kemps

SLR

Other

LISTINGS