CTintake

Phone:

Patient Information:

Date	SSN	Birthday
First Name	Middle Name	Last Name
Sex Male Female	Height	Weight
Married/Civil Union:	Spouse Name	# of Children
Home #	Cell #	Work #
Address		
City	State	Zip
Emergency Contact	Emergency Relation	Emergency Phone
Email		

Chiropractic Experience:

How did you hear about our office?

Have you been adjusted by a Chiropractor before? Yes No Was it a good or bad experience? Good Bad

Who was your previous Chiropractor?

What was the approximate date of your last adjustment?

Reason for this Visit:

What brings you into our office today (please select all that apply)?

Auto accident	Colic	Ear infection	Extremity pain
Fall/Injury	Flu/Cold Symptoms	Headaches/Migraines	Jaw pain/Clicking
Low back pain	Mid back pain	Neck pain	Numbness in arms
Sciatica	Stiff neck	Wellness	Work accident
Other			

Why is it important to you to seek treatment?

When did your health concern begin?

Is it getting better worse staying the same

Have you ever had anything like this before? Yes No

Does this concern interfere with: daily routine sleep work personal care family life other

Have you seen other doctors or health professionals for this concern?

If yes, what type of treatment did you receive:

Results: Good Bad

What is your end goal for care?

- Follow the recommended treatment plan to get out of pain, return to my normal routine, and then call as needed.
- Follow the recommended treatment plan to get out of pain, return to my normal routine, and then continue with preventative care.
- I'm not sure which option is right for me. Please help me decide.

Health Checklist:

Alcoholism	Allergies	Anemia
Arteriosclerosis	Arthritis	Asthma
Autoimmune Disease	Back Pain	Bleeding Disorders Bruise
Breast Lump	Bronchitis	Easily
Cancer	Cataracts	Chest Pain
Congestive Heart Failure	Cold Extremities	Constipation
COPD/emphysema	Cramps	CVA (stroke/TIA)
Dementia/Alzheimer's	Depression	Diabetes
Epilepsy	Digestion Problems	Dizziness
Fatigue	Excessive Menstruation	Eye Pain or Difficulties
Glaucoma	Frequent Urination	Gallbladder disease/stones
Gout	Headaches	Heart Attack
Hemorrhoids	High Blood Pressure	High Cholesterol
Hot Flashes	Irregular Menstrual Cycle	Kidney Infection
IBS	Liver disease/cirrhosis	Loss of Balance
Kidney Stones	Loss of Smell	Loss of Taste
Loss of Memory	Macular Degeneration	Migraines
Lung disease	Pacemaker	Parkinson's
Nosebleeds	Poor Posture	Prostate Trouble
Polio	Sciatica	Seizures
Retinal Disease	Sinus Infection	Skin Sensitivity
Shortness of Breath	Smoked	Spinal Curvatures
Sleep Problems/Insomnia	Swelling of Ankles	Swollen Joints
Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Other

Have you had any accidents, injuries, or broken bones to your head or body?

Yes If yes, please describe:

No

Have you had any surgeries?

Yes If yes, please describe:

No

Is there anything additional you'd like us to know?

Yes, please describe below:

No

EHR Information:

Preferred Language Ethnicity Race

Smoking Status Smoking Start Date Tried to quit? Yes No

Type of Tobacco Cigarettes Chewing Tobacco Cigar Pipe Other

How much tobacco do you use? How long have you used tobacco?

Current Medications And Dosage

Medication Allergies

I choose to decline receipt of my clinical summary after every visit

Signature

Date: