clearfield chiropractic

WELCOME!

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Name:_____ Date:_____ Referred by:_____
Address:_____ City/State/Zip_____
Phone #:_____ Cell #:_____ Birth date_____ Age:_____ Email:_____
Marital Status: Married Divorced Single Separated Widowed # of Children (if applicable) _____
Currently Employed: YES NO Occupation:_____ Place of Employment:_____ Work #:_____

Purpose for Today's Visit

If your visit is for a specific injury or complaint, please answer the questions below to your best ability.
(If some questions are difficult to answer, be assured that the doctor will be reviewing your information with you.)

Reason for your visit:
1._____ When did it begin?_____
2._____ When did it begin?_____
3. _____ When did it begin? _____

What caused your problem?_____
Have you experienced this in the past? YES NO If "yes", when?_____
Describe your problem (for example- sharp, dull, burning, stinging, ache, pin/needles, numbness, etc.)_____
_____
Does this problem travel in the body or stay in one place?_____
What makes it better?_____ What makes it worse?_____
Have you seen anyone else for this?_____ Have you tried anything else?_____
How has this problem affected your daily activities?_____
Additional comments relating to today's concern:_____
_____
Please list any other therapies or studies you've done, even if they are not related to today's complaint, such as an ***MRI,*** *CT Scan, Xrays, Massage, Physical Therapy* and list dates:_____
_____

Health Information

Have you been to a chiropractor before? YES NO If "yes", date of last adjustment_____
Purpose for last chiropractic care_____ Was there as reason you stopped?_____
How often did you go? Regular monthly visits Weekly Bi-weekly Only when symptoms present

Medical Doctor_____ Date of last exam_____ Other physicians_____
List any past injuries and/or accidents with dates_____
_____
List any surgeries & dates_____
_____
List anything you have been diagnosed with in the past / present_____
List prescription medications, OTC medications, supplements, vitamins taken_____
_____

Lifestyle

Rate your current state of health on a scale from 0-10, with "0"=poor and "10"=excellent…_____
Rate where you would like your health to be on a scale from 0-10 with "0"= poor and "10"=excellent…_____
Would you say you're healthier today than you were 5 yrs ago? YES NO

What kind of leisure activities/ hobbies do you enjoy?_____
Are you currently involved in an exercise program? YES NO If "yes", how many days/wk do you exercise?_____
Are you consistent with exercise? YES NO What do you do for exercise?_____
Is there anything preventing your from exercising at this time? YES NO If so, please describe_____

How many hours of sleep/ night do you get (on average)_____ Do you feel rested throughout the day? YES NO
Is your typical day stressful or noisy? YES NO If "yes", describe why_____
Describe your average breakfast_____ Describe your average lunch_____
_____ Describe your average dinner_____
Do you smoke? YES NO Drink alcohol? YES NO Drink caffeinated beverages? YES NO Drink water? YES NO
If you answered "yes" to any above, please describe daily, weekly or monthly consumption_____
_____

----------Goals For Your Chiropractic Care----------

(please "X" all that apply)

____Maintaining a healthy lifestyle ____Enhancing athletic performance ____Prevention of illnesses
____Relief for a specific injury or condition ____Improving your overall health without drugs or surgery

----------Past & Present Conditions----------

(please "X" all that apply)

____Allergies ____ Headaches ____Sinus Problems ____Blurred/ Double Vision ____Dizzyness
____Loss of Taste ____Frequent Colds/Flus ____Trouble Concentrating ____Trouble Sleeping ____Nervousnes
____Seizures/ Convulsions ____Anxiety ____Ear Infections ____Neck Pain ____Shoulder Pain (Right/ Left)
____Asthma ____Difficulty Breathing ____Wheezing ____Numbness in Arms/Hands /Fingers ____Heart Problems
____Stroke ____High/Low Blood Pressure ____Liver Problems ____Hernias ____Gall Bladder Problems
____Digestive Problems ____Acid Reflux ____Excessive Gas ____Diarrhea/ Constipation/ Colon Problems
____Thyroid Issues ____Heartburn ____Ulcers ____Mid Back Pain/ Stiffness _____ Colon Trouble
____Hemorrhoids ____Kidney Problems ____Frequent Urination ____Difficulty Urinating ____Prostrate Problems
____Impotence ____PMS ____Menstrual Problems ____Reproductive Issues ____Low Back Pain/ Stiffness
____Numbness in Leg/Feet/Toes ____Hip Pain (Right/ Left) ____Arthritis ____Swollen/ Painful Joints
____Autoimmune Disorders ____Auto Accident** please clarify____(0-1 yr ago) ____(1-5 yr ago) ____(+5 yrs ago)

----------Family Health History----------

Please circle any conditions you have a family history of: Arthritis Cancer Diabetes Heart Disease Scoliosis

----------Additional Comments/ Concerns----------

_____
_____
_____
_____

Thank you for completing our intake form.

Client Signature_____ Today's Date_____

------- *Only <u>Female Clients</u> Need to Read and Sign Below, Regarding Xray Safety* ----------

***Here at Clearfield Chiropractic Center, we want to ensure that each and every client receives the safest care possible. If by chance you are pregnant, it is important that we protect you from any unnecessary radiation that could affect the development of an unborn child, in uterus.

Is there a chance you may be pregnant? YES NO Date of last menses_____
By signing your name below, you deny pregnancy at this time and give permission to proceed with your Xray as needed.

Female Client Signature_____ Today's Date_____