PATIENT INTAKE FORM

Quintessential CHIROPRACTIC
The Ultimate in Gentle, Effective Care

Name: _____

Address: _____
Street

_____ Today's Date: _____
City State Zip

Date of Birth: _____ Age: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Carrier: _____

Appointment Reminder: Email ☐ Text ☐ Appointment Card ☐

Relationship status: _____ Spouse/Partner Name: _____

Emergency Contact: _____
Name Relationship Phone #

Occupation: _____ Years at this job: _____

Have you ever been adjusted by a Chiropractor? Yes ☐ No ☐

If yes, what was the reason for the visit? _____

Who can we thank for sending you to us? _____

Describe Reason for Today's Visit: _____

_____

When did you first notice it? _____ What caused it? _____

How is the condition now? Better ☐ Worse ☐ Same ☐ Comes and goes ☐

When does it occur? _____ How often? _____

How long does it last? _____ Does it travel? _____

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South Chesterfield, VA 23834
www.quintchiro.com 804-536-6262 www.facebook.com/QuintChiro

What makes it worse?

☐Driving
☐Walking
☐Sitting
☐Bending
☐Standing
☐Bowel Movement
☐Breathing
☐Coughing
☐Sleeping
☐Working
☐Exercising
☐Other _____

What makes it better?

☐Chiropractic
☐Rest
☐Lying Down
☐Sitting
☐Standing
☐Walking
☐Ice
☐Heat
☐Stretching
☐Massage
☐Medication
☐Nothing
☐Other _____

Rate your pain TODAY: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
(best) (worst)

Rate your AVERAGE pain: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
(best) (worst)

My condition interferes with: Work ☐ Sleep ☐ Daily Routine ☐ Other Activities ☐

Describe: _____

Have you had this condition before? Yes ☐ No ☐ When? _____

Have you seen another doctor for this? Yes ☐ No ☐ When? _____

Doctor's Name: _____ Phone #: _____

Were x-rays or other imaging studies performed? _____

Type of Treatment/ Results: _____

Health Habits & Lifestyle

Do you exercise? Yes ☐ No ☐

If yes, what type and how often? _____

_____

What activities/sports do you participate in? _____

_____

What position(s) do you sleep in? Back ☐ Right Side ☐ Left Side ☐ Stomach ☐

Hours per night? _____ Quality? Good ☐ Fair ☐ Poor ☐ Interruptions per night? _____

Personal Health History

List any medications and why you are taking each one (including over-the-counter)

_____

_____

_____

Have you ever had any surgeries or been hospitalized? Yes ☐ No ☐

When and for what? _____

_____

Please list all accidents and injuries you've had, including childhood: (include dates) _____

_____

Goals of Care (choose all that apply)

- ☐ Relief of pain: Removing symptoms of pain and discomfort
- ☐ Corrective Care: correcting/relieving the cause of the problems as well as the symptoms
- ☐ Comprehensive care: bringing your body to optimal health

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits. Chiropractic care is an important addition to a healthier lifestyle but requires TIME to allow your body to heal.

We ask that you commit to 12 visits in order to maximize your response to the care received in this office*

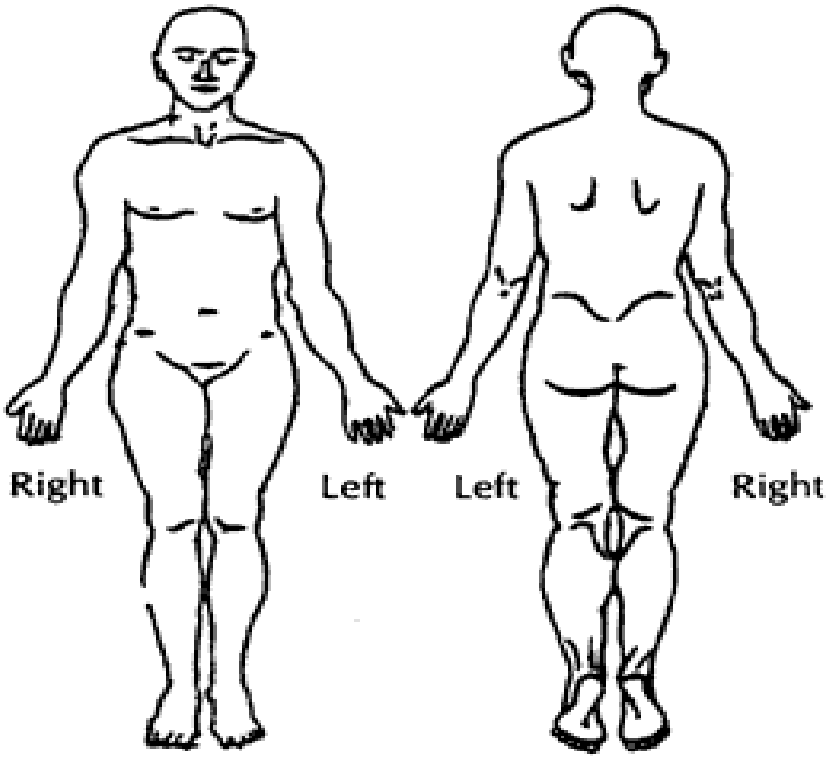
I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Guardian's Name (if minor patient): _____ Relationship: _____

Guardian's Signature (if minor patient): _____

Patient Name _____ Date _____



PAIN DIAGRAM

Please mark the location(s) of your pain using the following symbols:

N = numbness/tingling
^ = sharp/stabbing
B = burning
S = shooting/travelling
A = aching
O = other (describe)
T = tightness

Additional information regarding pain: _____

_____

_____

Doctor's Notes:_____

_____

_____

_____ _____

Doctor Signature Date