JG Chiropractic

Initial Patient Intake Form

Please Print: *Today's Date:*

Name:	**DOB:**	
Address:		
City:	**State:**	**Zip:**
Phone number:	**Cell number:**	**Email:**
Primary Care Doctor:	**Phone:**	
Occupation: **Employer:**	**Who referred you to our office:**	
Have you undergone chiropractic treatment before?	**Where?**	
When?	**Technique?**	

What are your health goals?

_____Correction/stabilization _____Health Maintenance _____Pain Relief

Please check area of complaint (circle side of pain):

____ Low back pain R or L
____ Hip/buttock pain R or L
____ Leg pain R or L
____ Foot Pain R or L
____ Shoulder Pain R or L
____ Arm Pain R or L
____ Hand Pain R or L
____ Neck Pain
____ Mid-back Pain
____ Other:

When did the pain begin?

_____Gradually, without incident _____ Specific incident

Explain the incident/injury or how you think it occurred:

What makes the symptoms worse?

___ Sitting	___ Looking down	____ Turning in Bed
___ Getting out of chair	___ Sneezing	____ Having bowel movement
___ Getting out of bed	___Coughing	____ Backing up in car

How does the pain feel?

___ Sharp	___ Burning	Other:
___ Dull	___ Numbness	
___ Throbbing	___ Tingling	
___ Cramping	___ Weak or lame	

Does the pain or symptom travel from one side to another? ____ Yes ____ No
Explain:

How much does it hurt? 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain; 10 = severe pain)

Does your pain change with activity? ____ Yes ____ No
Explain:

Please check the following:

1. Have you/family had cancer?	**____ Yes ____ No**
Who/type?	
2. Are you losing weight without trying?	**____ Yes ____ No**
3. Does your pain awaken you from sleep?	**____ Yes ____ No**
4. Are you coughing up blood or noticing blood in your stool or urine?	**____ Yes ____ No**
5. Have you ever had loss of bladder/bowel control?	**____ Yes ____ No**
6. Have you lost consciousness or had double vision recently?	**____ Yes ____ No**
7. Do you have a pacemaker?	**____ Yes ____ No**
8. Are you seeing another doctor now for any reason?	**____ Yes ____ No**
Specify:	
9. Do you have any other symptoms or health problems?	**____ Yes ____ No**
Specify:	
10. Are you taking prescription or over the counter medications?	**____ Yes ____ No**
Specify:	

Do you have food allergies? ____ Yes ____ No **Specify:**		
Dietary habits? (ie. daily intake of fruits, vegetables, red meat, sugar)		
Do you drink alcohol?	**Do you smoke?**	**Sleep habits?**
Past treatment history:		

Signature: _____ **Date:** _____