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Client Intake Form

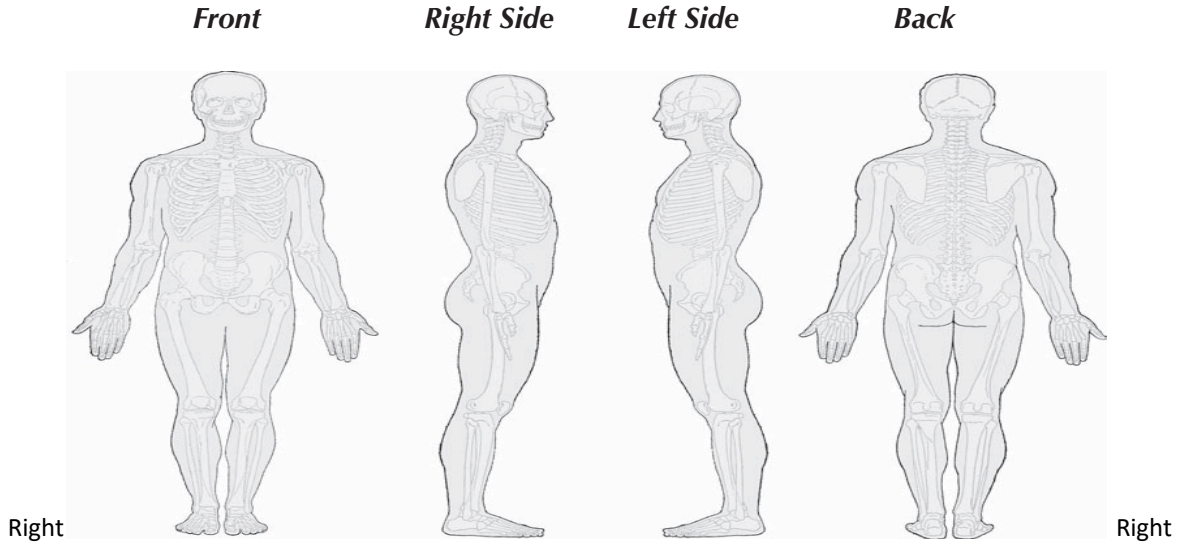
We appreciate the opportunity to serve you. Your responses are important to help better understand you and deliver the best possible health outcomes.

Date _____

Patient Information		
First Name	Last Name	
Preferred Name	DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O
If under 18 – Parent/Guardians Name		
Postal Address	City	
State	Postcode	Email
Phone	Mobile	
Occupation		
Emergency Contact Name	Emergency Phone	
Name of Medical Doctor	Health Fund	
Who can we thank for telling you about us?		

Current Condition	
What brings you into the office today?	
Have you had care for this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain	
When did the complaint start?	How did the complaint begin <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually <input type="checkbox"/> Post Injury
Have you ever experienced these symptoms before <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, When?	
If there is pain, is it radiating anywhere? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have tingling in your legs <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it cause you pain to cough or sneeze? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have impairment of bowel or bladder function? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this problem interfere with your sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please Mark on the picture below the areas where you are experiencing pain:



On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain, use the key to the right and rate your severity of pain:

Right Now, what is the intensity of your pain?

01.....2.....3.....4.....5.....6.....7.....8.....9.....10

What is the least intense this problem has been?

01.....2.....3.....4.....5.....6.....7.....8.....9.....10

What is the most intense this problem has been?

01.....2.....3.....4.....5.....6.....7.....8.....9.....10

- 0 = No Pain**
 1 = Minimal
 2 = Very Mild
 3 = Mild
 4 = Mild to Moderate
5 = Moderate
 6 = Moderate to Severe
 7 = Moderately Severe, restricts some activity
 8 = Severe – limits most activity
 9 = Very severe
10 = Excruciating

What are your top 3 health goals

1

2.

3.

Chiropractic Care

What type of Chiropractic care are you looking for?

Acute Care (Have no pain)
 Maintenance Care (want to keep the pain away)
 Wellness Care (want to have optimal health)



Physical History	
Have you ever had significant falls, surgeries, or other injuries as an adult? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain _____	
Any notable childhood injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain	
Sports (now or when younger) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, any injuries?	
Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain	
How do you normally sleep <input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach Do you wake up <input type="checkbox"/> Refreshed <input type="checkbox"/> Tired	
How many hours a day do you spend on computers, phones, tablets or at a desk?	
Is your blood pressure <input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Don't know	
List any problems with flexibility (putting on shoes or socks)	

Chemical and Environmental Exposure - Please rate your consumption															
	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Alcohol	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Water	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugar	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Dairy	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Gluten	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Please List Any Drugs/ Medications/ Vitamins/ Herbs that you are taking.

Additional Information
Anything you want us to know before beginning care?



Health History			
Please Check all additional complaints you have at this time, or had regularly in the past			
<input type="checkbox"/> Loss of Concentration	<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Eyes Sensitive to light	<input type="checkbox"/> Upper Back Stiffness	<input type="checkbox"/> Digestive trouble	<input type="checkbox"/> Dental Appliances
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Anaemia
<input type="checkbox"/> Heavy Feeling in head	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Unusual Weight Loss
<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Pain Behind the Eyes	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Heavy Light Periods	<input type="checkbox"/> Headaches
<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Migraines
<input type="checkbox"/> Fainting/ Lightheaded	<input type="checkbox"/> Pins and Needles in Arms or legs	<input type="checkbox"/> Cold Hands and Feet	<input type="checkbox"/> Stroke
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Loss of Feeling	<input type="checkbox"/> Anxiety/ Depression	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Hernia
<input type="checkbox"/> Cancer (List)			
<input type="checkbox"/> Allergies (List)			

Do you have, or have you ever had, any diseases or medical problems not mentioned

Yes No

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____