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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 ☐M ☐ F ☐Other
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? ☐ Yes ☐ No If yes, please explain	
When did the complaint start?	**How did the complaint begin** ☐Suddenly ☐ Gradually ☐ Post Injury
Have you ever experienced these symptoms before ☐ Yes ☐No If yes, When?	
If there is pain, is it radiating anywhere? ☐ Yes ☐ No	**Do you have tingling in your legs** ☐ Yes ☐ No
Does it cause you pain to cough or sneeze? ☐ Yes ☐ No	
Do you have impairment of bowel or bladder function? ☐ Yes ☐ No	
Does this problem interfere with your sleep? ☐ Yes ☐ No	

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

Front ***Right Side*** ***Left Side*** ***Back***

Right Right

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?

0 ....1……….2……….3……….4……….5……….6……….7……….8……….9……….10

What is the least intense this problem has been?

0 ....1……….2……….3……….4……….5……….6……….7……….8……….9……….10

What is the most intense this problem has been?

0 ....1……….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)

*Patient Name*____________________________________ *ID NUMBER*______________

Physical History

Have you ever had significant falls, surgeries, or other injuries as an adult? ☐ **Yes** ☐ **No**

If Yes, please explain ____

Any notable childhood injuries? ☐ **Yes** ☐ **No** **If yes, explain**

Sports (now or when younger) ☐ **Yes** ☐ **No** **If yes, any injuries?**

Fractures ☐ **Yes** ☐ **No** **If yes, explain**

How do you normally sleep ☐ **Back** ☐ **Side** ☐ **Stomach** **Do you wake up** ☐ **Refreshed** ☐ **Tired**

How many hours a day do you spend on computers, phones, tablets or at a desk?

Is your blood pressure ☐ **Normal** ☐ **High** ☐ **Low** ☐ **Don't know**

List any problems with flexibility (putting on shoes or socks)

Chemical and Environmental Exposure - Please rate your consumption

	None		Moderate		High		None		Moderate		High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweetener	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	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?

*Patient Name*________________________ *ID NUMBER*____________

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

PAYMENT POLICY: All fees are to be paid in full on the day of service

DEPOSITS: Deposits may be required to secure a booking including first appointments, and others at the discretion of New England Chiropractic.

Patient Signature____ Date_______________

Patient Name____________________________________ ID NUMBER_____________