SUNSET CHIROPRACTIC INTAKE FORM

Name:_____Date:_____/_____/_____Age:_____Male/Female (circle)

Address:_____City:_____ State:_____Zip:_____

Phone: Home_____Cell:_____ Date of Birth:_____/_____/_____

Email Address:_____ Height:_____ Weight:_____

Occupation:_____ Employer's Name:_____

Single / Married / Divorced / Widowed Spouse's Name:_____

Number of Children_____ Are you currently Pregnant? Y / N

Are you currently or have you ever smoked? Y / N How many years? _____

Who may we thank for referring you? _____

What treatment(s) are you interested in? (Circle all that apply)

Chiropractic Softwave Therapy

What type of care are you interested in? (Circle one)

Relief Care (get rid of symptoms) **Corrective Care** (fix the cause of the problem) **BOTH** (relief and corrective care)

Have you had Chiropractic care before? Yes No **Is this related to an auto accident?** Yes* No

If yes, please stop here and see our reception desk to get all of the proper auto accident forms

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	***THROAT ISSUES***	***KIDNEY PROBLEMS***	***LIVER DISEASE***	***NERVOUSNESS***
HEADACHES	***THYROID PROBLEMS***	***MID BACK PAIN***	***SHOULDER PAIN***	***EPILEPSY***
VERTIGO	***ASTHMA***	***IRRITABLE BOWEL***	***CHRONIC FATIGUE***	***DISC PROBLEM***
EAR INFECTIONS	***ULCERS***	***SCIATICA***	***LUPUS***	***INFERTILITY***
NAUSEA	***NUMBNESS IN ARMS***	***NUMBNESS IN LEGS***	***FIBROMYALGIA***	***GASTRIC REFULX***
TMJ	***NUMBNESS IN HANDS***	***NUMBNESS IN FEET***	***CHEST PAIN***	***ALLERGIES***
NECK PAIN	***MENSTRUAL DISORDER***	***LOW BACK PAIN***	***ARM PAIN***	***OTHER_____***
MIGRAINES	***HEART DISORDERS***	***HIP PAIN***	***ADD/ADHD***	_____
ANXIETY	***STOMACH DISORDERS***	***LEG PAINS***		_____
CHRONIC SINUS	***BLADDER PROBLEMS***	***KNEE PAIN***		_____

LIST YOUR TOP 3 HEALTH PROBLEMS

Health Concerns: List according to severity	**Rate of Severity 1 = mild 10 = unbearable**	**When did this episode start?**	**If you had the condition before, when?**	**Did the problem begin with an injury?**	**Are symptoms constant or intermittent?**
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

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CIRCLE ANY CONDITION YOU HAVE NOW OR HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

List any surgical operations and year _____

_____

List ANY over the counter & PRESCRIPTION MEDICATIONS you are on:

_____

_____

AUTO ACCIDENT HISTORY: Year Speed (MPH) Rear-ended? T-Boned?

_____

_____

Have you ever been knocked unconscious? YES / NO **Fractured a bone?** YES / NO

If yes, please describe_____

Other trauma:_____

Activities of Daily Living

Please circle how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITY:	EFFECT:			
EXAMPLE: Running	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sit to stand	No effect	Painful (can do)	Painful (limits)	Unable to perform
Climbing stairs	No effect	Painful (can do)	Painful (limits)	Unable to perform
Driving	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sitting	No effect	Painful (can do)	Painful (limits)	Unable to perform
Standing	No effect	Painful (can do)	Painful (limits)	Unable to perform
Walking	No effect	Painful (can do)	Painful (limits)	Unable to perform
Dressing	No effect	Painful (can do)	Painful (limits)	Unable to perform
Lifting Children	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sexual activities	No effect	Painful (can do)	Painful (limits)	Unable to perform
Washing/Bathing	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sweeping/Vacuuming	No effect	Painful (can do)	Painful (limits)	Unable to perform
Yard work	No effect	Painful (can do)	Painful (limits)	Unable to perform
Exercise	No effect	Painful (can do)	Painful (limits)	Unable to perform
Other:_____	No effect	Painful (can do)	Painful (limits)	Unable to perform