Innate Chiropractic Health, LLC
Patient Intake Form

Patient Information Date: ____________

First Name: ________________________ Middle Initial: _____

Last Name: ____

Address: ____

City: ____

State: _______________ Zip Code: ______________________

Sex: M / F Age: ____________ Birth date: ____/____/___

Demographics: Decline to Specify: ☐
Race/Ethnicity: __________________
Preferred Language: ______________

Please Circle:
Married/Single/Widowed/Minor/Separated/Divorced/Partnered

Occupation: ____

Patient Employer/School: ______________________________

Spouse's Name: ____

How did you hear about us: Internet Facebook Phone Book
Friend/Family/Other: ___________________________

Contact Information

Home phone: ____

Mobile phone: ____

Work phone: ____

E-mail: ____

Emergency Contact

Name: ____

Relationship: ____

Phone number: ____

Patient Condition

Reason for your visit: ________________________________

When did symptoms appear? _____________________________

Where is the pain or discomfort located? _______________

Is it on the right, left, or both sides? ______________________

Is the pain constant or coming/going? _________________

Rate your current pain: 0 1 2 3 4 5 6 7 8 9 10

Please circle the type or types of pain: sharp dull throbbing aching shooting burning numb tingling cramping stiff swelling other: ______________________________________

Please circle all that apply:
My pain interferes with work/sleep/recreation/daily routine/ none of these/other: ___________________________________

Please circle all that apply:
My pain is increased with sitting/standing/bending/lifting walking/lying down/other: ______________________________

Please circle all that apply:
Pain symptoms are improved with ice/heat/medications/rest/ other: ____

Is this condition due to an accident? Y/N
If so, when did this accident occur? Date: ________________
Was the accident reported? Y/N
To whom was the accident reported to? __________________
Do you have an attorney regarding this accident? Y/N
Name of attorney: ____________________________________

Medications/Supplements
Please list any medications/supplements you are currently taking, their dosage, and the month/year when you began taking them (please estimate to the best of your ability):

Prescription	Dose	Date

© Innate Chiropractic Health, LLC (2015 – present) All office forms cover treatment by Dr. Cassandra J. Baar Cook, DC

Health History

What treatment have you already received for this complaint?
medications physical therapy surgery chiropractic
acupuncture massage therapy none
other: ____

Date of most recent:
Physical exam: _____________ Spinal exam: _____________

Lab work: _________________ X-ray: _________________

MRI/CT Scan/Bone Scan: ___________________________

Are you pregnant? Y/N Due date: ______________________

Please list any medication allergies: _____________________

Do you have any implantable devices: ____________________

Activities

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing Light labor Heavy labor

High Stress Level: Reason: ___________________________

Habits

Smoking History:
Current: Y/N Packs per day: ____________________
Past: Y/N Start (YY): _______ Quit (YY): _____
Interested in smoking cessation? Y / N

Alcohol: Drinks per week: _____________________________

Coffee/Caffeine Drinks: Cups per day: ___________________

Injuries/Surgeries

Please list any injuries or surgeries you have had. Please also list the date that the injury or surgery occurred.

Falls: ____

Head Injuries: ______________________________________

Fractures: ____

Dislocation: ____

Surgeries: ____

Family History

Please list any of your family members (parents, grandparents, brothers, and sisters) that have or have had these conditions.

Heart Disease: ______________________________________
Stroke: ____
Lupus: ____
Multiple Sclerosis: ___________________________________
High Blood Pressure: _________________________________
Rheumatoid Arthritis: _________________________________
Diabetes: ____
Cancer: ____
Other: ____

© Innate Chiropractic Health, LLC (2015 – present) All office forms cover treatment by Dr. Cassandra J. Baar Cook, DC