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 / Divorced / Partnered

Occupation: _____

Employer/School: _____

Spouse/Partner's Name: _____

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

Contact Information

Mobile phone: _____

Home phone: _____

E-mail: _____

Emergency Contact

Name: _____

Relationship: _____

Phone number: _____

Patient Condition

Reason for your visit: _____

When did symptoms appear? _____

Where are symptoms 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 start date.

Prescription **Dose** **Date**

_____
_____
_____
_____
_____

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: _____ Lab work: _____

MRI/CT Scan/Bone Scan: _____

Are you pregnant? Y/N Due date: _____

Please list any medication allergies: _____

Activities

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing Light labor Heavy labor

High Stress due to: _____

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: _____