NEW CLIENT INTAKE FORM

Name_____Date_____

Address_____

City_____State_____Zip_____

Home Phone_____ Cell Phone_____

Email_____Cell Phone Company (for texting):_____

Date of Birth_____ Gender_____ Height_____ Weight_____

Name of Your Employer:_____

Type of Work:_____

Referred to this office by:_____

Circle if you are: Single Married Widowed Divorced Separated

Name and Phone number of person to contact in case of emergency:_____

_____

LIST YOUR MAJOR PRESENT HEALTH COMPLAINT (IN ONE SENTENCE):_____

_____

DURATION OF PRESENT CONDITION (HOW LONG):_____

Have you been treated before for this problem? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Chiropractor ☐ Physical Therapist ☐ Osteopath

☐ Other:_____

What did they do and/or recommend?_____

What was their diagnosis?_____

Is this condition getting progressively worse? ☐ No ☐ Yes

Fractures or dislocations:_____

_____

Drugs (medications) you are currently taking:_____

_____

Allergies:_____

Have you ever had a nervous breakdown?_____

Have you ever been treated for any mental disorders?_____

CIRCLE ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:

Alcoholism
Anemia
Appendicitis
Arthritis
Breast Lumps
Cancer
Chicken Pox
Diabetes
Diphtheria
Eczema
Epilepsy
Goiter
Gout
Heart Disease
Hepatitis
High Cholesterol
Hernia
Influenza
Kidney Disease
Liver Disease
Lumbago
Malaria
Measles
Mental Disorders
Migraine Headaches
Multiple Sclerosis
Mumps
Pacemaker
Pleurisy
Polio
Pneumonia
Rheumatic Fever
Scarlet Fever
Stroke
Smallpox
Tuberculosis
Typhoid Fever
Ulcers
Venereal Infection
Whooping Cough

Other:_____

Please underline all of the following symptoms you have had PREVIOUSLY.
Please circle all of the symptoms you have NOW.

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Numbness / pain in arms, hands, or legs
Allergy
Wheezing
Weight gain
Loss of weight
Loss of sleep
Bruises easily
Neuralgia

E.E.N.T.
Failing vision
Nearsightedness
Farsightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nosebleeds
Nasal obstruction
Sore throat
Hoarseness
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay fever

SKIN
Skin Eruptions
Itching
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy
Sores that wouldn't heal

RESPIRATORY
Chronic cough
Spitting-up phlegm
Spitting-up blood
Chest pain
Difficulty breathing

CARDIOVASCULAR
Rapid heartbeat
Slow heartbeat
High blood pressure
Low blood pressure
Pain over heart
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke
Chest pain

GENITOURINARY SYMPTOMS
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection of stones
Bed wetting
Inability to control urine
Prostate trouble

GATROINTESTINAL
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR MEN ONLY
Breast lumps
Erection difficulties
Lump in testicle
Penis discharge
Sore on penis
☐ Other:_____

FOR WOMEN ONLY
Are you pregnant?____
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Painful menstrual periods
☐ Other:_____

NECK, BACK, EXTREMITIES: Please underline all of the following symptoms you had previously. Please circle all of the symptoms you have NOW.

NECK

Pain in neck
Neck stiffness
Neck weakness
Pinched nerve in neck
Neck feels out of place
Muscle spasms in neck
Grinding/popping sounds in neck

SHOULDERS

Pain in shoulder joint ☐ Right ☐ Left
Pain across shoulders
Can't raise arm ☐ Right ☐ Left
☐ Above shoulder level
☐ Over head
Tension in shoulders
Pinched nerve in shoulder ☐ Right ☐ Left

MID-BACK

Mid-back pain
Mid-back stiffness
Pain between shoulder blades
Pain from front to back
Muscle spasms in mid-back

LOW BACK

Low back pain
Low back stiffness
Low back weakness
Pinched nerve in low back
Low back feels out of place
Muscle spasms in low back

ARMS & HANDS

Pain in upper arm ☐ Right ☐ Left
Pain in elbow ☐ Right ☐ Left
Pain in forearm ☐ Right ☐ Left
Pain in hand ☐ Right ☐ Left
Pain in fingers ☐ Right ☐ Left
Pins & needles in fingers ☐ Right ☐ Left
Numbness in arm ☐ Right ☐ Left
Numbness in fingers ☐ Right ☐ Left
Weakness of arm ☐ Right ☐ Left
Weakness of hand ☐ Right ☐ Left
Hands cold ☐ Right ☐ Left

HIPS, LEGS & FEET

Pain in buttocks ☐ Right ☐ Left
Pain in hip joint ☐ Right ☐ Left
Pain down leg ☐ Right ☐ Left
Pain in ankle ☐ Right ☐ Left
Pain in foot ☐ Right ☐ Left
Weakness of leg ☐ Right ☐ Left
Weakness of knee ☐ Right ☐ Left
Leg cramps ☐ Right ☐ Left

OTHER SYMPTOMS

_____
_____
_____
_____
_____
_____

PAST HEALTH HISTORY

OPERATIONS/SURGERIES AND YEARS PERFORMED:_____
_____

Organs/Glands removed:_____

VACCINATIONS AND INJECTIONS RECEIVED:

☐ Diphtheria ☐ Polio ☐ Tetanus ☐ Spinal tap or injections ☐ Typhoid ☐ Smallpox
☐ Other:_____

HABITS: ☐ Coffee ☐ Tea ☐ Alcohol ☐ Tobacco
☐ Exercise ☐ Hobbies ☐ Sleep (Hours):_____

ACCIDENTS OR FALLS (Please Describe):_____
_____

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The information collected during a frequency analysis is used to support the muscular, skeletal, inflammatory, and immune responses.

_____ _____

Signature Date