Serenity Chiropractic and Wellness

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PATIENT INTAKE FORM

Name _____ Date _____

Address _____ State _____ Zip _____

Birth Date _____ Gender _____ Age _____ Height _____ Weight _____

Phone _____ Email _____ Occupation _____

Emergency contact _____ How did you learn about us? _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Other _____

Health concerns

List your main health concerns	Rate Severity 0 mild & 10 Severe	When did it start?	Did it start with an injury?	Constant pain or intermittent

What makes it worse? _____

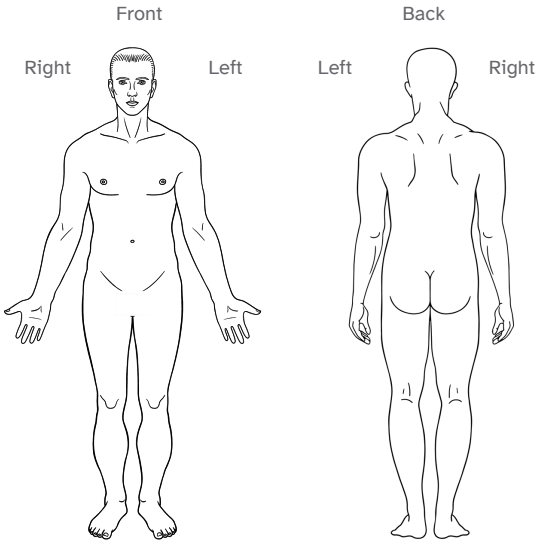
What makes it better? _____

Have you seen any Doctor/Health Provider for this condition? _____

If so, when and who? _____

List all medications currently taking _____

Please mark where you have pain or symptoms.



Please check the symptoms. (Mark all appropriate)

- ☐ Sharp
- ☐ Shooting
- ☐ Numbness
- ☐ Dull
- ☐ Aching
- ☐ Throbbing
- ☐ Stabbing
- ☐ Stiffness
- ☐ Uncomfortable
- ☐ Tenderness
- ☐ Swelling
- ☐ Nagging
- ☐ Tingling
- ☐ Cramping
- ☐ Other _____

Out of 10, mark the severity of your symptoms.

0 1 2 3 4 5 6 7 8 9 10

No Symptoms — Intense Symptoms

Health and illness History

- ☐ Allergies
- ☐ Neck Pain
- ☐ Migraine
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ High BP
- ☐ Fracture
- ☐ Sciatica
- ☐ ADD/ADHD
- ☐ Digestive Issue
- ☐ Immune Issue
- ☐ Chest Pain
- ☐ Stroke
- ☐ Heart Disorder
- ☐ TMJ
- ☐ Blood Clot
- ☐ Surgery
- ☐ Urinary Issue
- ☐ Kidney Issue
- ☐ Bladder Issue
- ☐ Menstrual Issues
- ☐ GRED
- ☐ Surgery
- ☐ Osteoporosis
- ☐ Cardiovascular
- ☐ Asthma
- ☐ Epilepsy
- ☐ Thyroid Issue
- ☐ Varicose Veins
- ☐ Other _____

Have you experienced any of these? ☐ Auto Crash ☐ Accident ☐ Sport Injury ☐ Hospitalisation

Are you currently pregnant? ☐ Yes ☐ No

Signature _____ Name _____ Date _____