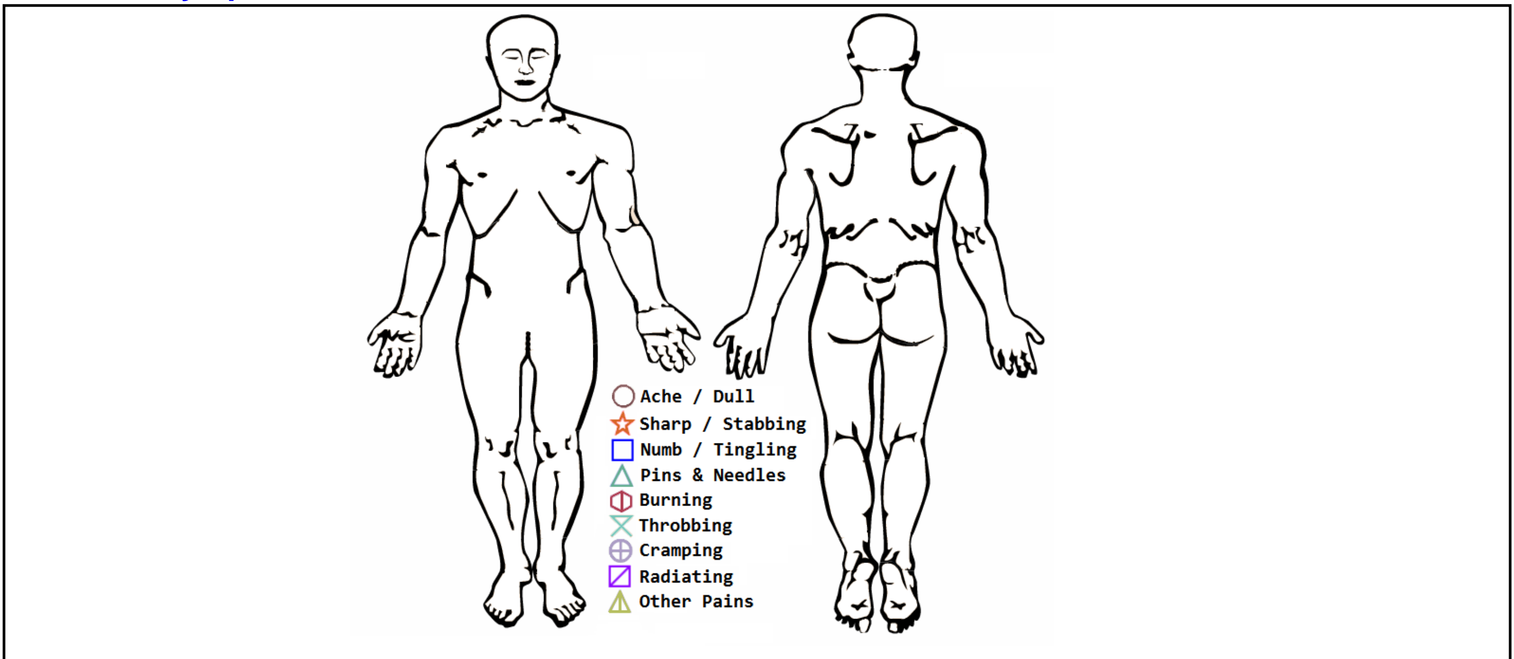
CTintake

Phone:

Patient Information:

Date			SSN	Birthday
First Name			Middle Name	Last Name
Sex	Male	Female	Height	Weight
Married/Civil Union:			Spouse Name	# of Children
Home #			Cell #	Work #
Address				
City			State	Zip
Emergency Contact			Emergency Relation	Emergency Phone
Email				

Patient Symptoms:



Patient Social

Alcohol:	Daily	Weekly	Occasionaly	Never	Caffeine:	Daily	Weekly	Occasionaly	Never
Diet Food Products:	Daily	Weekly	Occasionaly	Never	Drugs:	Daily	Weekly	Occasionaly	Never
OTC Stimulants:	Daily	Weekly	Occasionaly	Never	Exercise:	Daily	Weekly	Occasionaly	Never
Homemade Food:	Daily	Weekly	Occasionaly	Never	Processed:	Daily	Weekly	Occasionaly	Never
Soft Drinks:	Daily	Weekly	Occasionaly	Never	Tobacco:	Daily	Weekly	Occasionaly	Never
Water:	Daily	Weekly	Occasionaly	Never					

Chiropractic Experience:

Who referred you to our office:

Where did you hear about us? Newspaper Sign Yellow Pages Mailing Community Event Other

Have you been adjusted by a chiropractor before? Yes No If yes, Why?

Doctor's Name: Approximate Date of Visit

Has any member of your family ever seen a wellness chiropractor? Yes No

Employer Information:

Employed: Employer Name

Employer Address:

Employer City: Employer State: Employer Zip:

Occupation: Work Supervisor: Supervisor #:

Work Duties:

Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life.

Wellness Sports Auto Fall Home Injury Job Chronic Discomfort Other

Briefly Explain:

When did this concern begin? Has this concern: Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with: Work Sleep Daily Routine Other Activities

Briefly Explain:

Has this concern occurred before? Yes No

Briefly Explain:

Have you seen other doctor's for this concern? Yes No Doctor's name:

Type of Treatment:

Results: Good Bad Indifferent

For Women Only:

Are you pregnant? Yes No Are you taking birth control? Yes No Do you take HRT? Yes No

Are you nursing? Yes No Do you experience painful periods? Yes No Do you have irregular cycles? Yes No

Do you perform a regular self breast examination? Yes No Do you have breast implants? Yes No

Do you take oral contraceptives? Yes No

Date of last PAP/pelvic exam? Date of last mammogram? Date of Last Menstrual Period?

Insurance Information:

Payment Name	Primary Phone #	Primary ID/Policy
Payment Address		
Payment City	Payment State	Payment Zip
Primary Group #	Primary Name	Primary DOB
Secondary Name	Secondary Phone #	Secondary ID/Policy
Secondary Address		
Secondary City	Secondary State	Secondary Zip
Secondary Group #	Secondary Name	Secondary DOB
Claim #	Claim Contact	Claim #
Attorney Name	Attorney Phone #	

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

I want the Doctor to select the type of care appropriate for my condition

Relief care: Symptomatic relief of pain or discomfort.

Corrective care: Correcting and relieving the cause of the problem as well as the symptom

Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Personal Health History

Last Physical Exam:	Primary Phys:	Phys Phone #:
Phys City:	Phys State:	Phys Zip:

Health Conditions:

Previous Chiro Care:	Yes	No	Date:			Condition(s) treated:
Chance Pregnant:	Yes	No	Planning:	Yes	No	

Medications:

Supplements:

Personal Incident History:

Broken Bones:	Yes	No	Treatment:	Yes	No	Explain
Sprains/Strains:	Yes	No	Treatment:	Yes	No	Explain
Hospitalized:	Yes	No	Explain:			
Surgery:	Yes	No	Explain:			
Auto Accident:	Yes	No	Treatment:	Yes	No	Explain
Struck Unconscious:	Yes	No	Treatment:	Yes	No	Explain
Eating Disorder:	Yes	No	Explain:			
Stroke:	Yes	No	Explain:			

Health Checklist:

Alcoholism	Allergies	Anemia
Arteriosclerosis	Arthritis	Asthma
Autoimmune Disease	Back Pain	Bleeding Disorders
Breast Lump	Bronchitis	Bruise Easily
Cancer	Cataracts	Chest Pain
CHF	Cold Extremities	Constipation
COPD/emphysema	Cramps	CVA (stroke/TIA)
Dementia/Alzheimer's	Depression	Diabetes
Diagnosed emotional/mental	Digestion Problems	Dizziness
Epilepsy	Excessive Menstruation	Eye Pain or Difficulties
Fatigue	Frequent Urination	Gallbladder disease/stones
Glaucoma	Gout	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heart Beat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Liver disease/cirrhosis	Loss of Balance
Loss of Memory	Loss of Smell	Loss of Taste
Lung disease	Macular Degeneration	Migraines
Nosebleeds	Pacemaker	Parkinson's
Polio	Poor Posture	Prostate Trouble
Retinal Disease	Sciatica	Seizures
Shortness of Breath	Sinus Infection	Skin Sensitivity
Sleep Problems/Insomnia	Smoked	Spinal Curvatures
Stroke	Swelling of Ankles	Swollen Joints
Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Other

Have you had any of these Cardiovascular Diseases? Please select all that apply.

Myocardial infarction	Hypertension	Hypercholesterolemia
Bypass surgery	Coronary artery disease	

Do you have Diabetes? If so what type?

Type I   Type II   Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

Ulcers	Reflux	IBS

Family Health History:

Family Health History

Accident Information:

Date and time of accident:

Name of the location/street on which you were traveling:

Were you the: Driver Front Passenger Rear Passenger Make and model of the vehicle you were occupying:

Was this vehicle equipped with airbags? Yes No Did the airbags inflate? Yes No Were you wearing a seat belt? Yes No

Did the impact to you vehicle come from the: Front Rear Right side Left side Other

In relation to the base of your skull, where was the headset? Above Below At the base

In which direction were you headed? North South East West

Direction the other vehicle was headed? North South East West

During impact, were you facing: Forward Right Left

Did any part of your body strike anything in the vehicle? Yes No

Explain:

Did the accident render you unconscious? Yes No If yes, for how long?

What was the approximate speed of the your vehicle? the OTHER vehicle?

Were you Aware Surprised by the impact

What did your vehicle impact? Vehicle Other

If other, please explain below:

Number of people in the accident vehicle:

Please list the names of the victims in this accident:

If your own words, please describe the accident:

Please describe how you felt immediately after the accident:

Did the police come to the accident scene? Yes No Was a police report filed? Yes No

Were there any witnesses? Yes No

Was a traffic violation issued? Yes No

To whom:

Accident Information (2):

Have you retained an attorney? Yes No If yes, whom? Phone:

Have you gone to a hospital or seen any other doctor? Yes No When did you go? Immediately Next Day 2 Days Plus

How did you get there? Ambulance Private Transportation Was medication prescribed? Yes No

Name of the hospital and/or attending doctor:

Was he / she a: D.D.S M.D. D.C. D.O. Were any X-rays taken? Yes No

Have you been able to work since this injury? Yes No Are you work activities restricted as a result of this injury? Yes No

Signature Date: