Jade Chiropractic & Wellness Center

Intake Form

Patient Information

Name:_____Date: _____
Date of birth: _____
Street address: _____
City:_____State:_____Zip code: _____
Home phone:_____Cell phone: _____
Email address: _____
What is the best way to reach you? ☐ Home ☐ Cell ☐Work ☐ Text ☐Email
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Spouse's name: _____
Number of children: _____
Occupation:_____Employer: _____
Work Phone: _____
Emergency contact name/Phone: _____
Insurance Provider/ID#/Group #: _____

Whom may we thank for referring you? _____

Health Information

What is the reason for your visit? ☐ Wellness ☐ Physical Complaint ☐ Accident ☐ Other
*If you checked Wellness, please proceed directly to the Lifestyle section (page 4)
1. Please circle any of the following physical complaints you have:

Headaches
Neck pain
Neck stiffness
Mid back pain
Mid back stiffness
Low back pain
Low back stiffness

Left shoulder pain
Left arm pain
Left wrist pain
Radiating pain into left shoulder
Radiating pain into left arm
Numbness/Tingling to left hand

Right shoulder pain
Right arm pain
Right wrist pain
Radiating pain into right shoulder
Radiating pain into right arm
Numbness/Tingling to right hand

Left sacrum--iliac pain (tailbone)
Left hip pain
Left leg pain
Left knee pain
Left foot pain
Numbness/Tingling to left foot

Right sacrum--iliac pain (tailbone)
Right hip pain
Right leg pain
Right knee pain
Right foot pain
Numbness/Tingling to right foot

Other:_____

2. When did your symptoms begin? _____

3. What was the mode of onset?

Not doing anything at time of onset	Motor vehicle accident	Work Injury
Overextending	In strenuous position	Fell
Lifting an object	Other: _____	

4. How soon did the symptoms come on?

Immediately	Few hours later	Next day
Few days later	About a week later	Slowly over time
Other: _____		

5. Have you experienced these symptoms before? □ Yes □ No

6. When do you first remember experiencing these symptoms? _____

7. What seems to increase the symptoms?

Nothing	Coughing	Bending	Lifting	Walking
Reaching	Sitting	Standing	Pulling	Turning
Other: _____				

8. What seems to diminish the symptoms?

Nothing	Rest	Sitting	Stretching	Exercise	Standing
Ice	Heat	Medication			
Other: _____					

9. How would you characterize the pain?

Burning	Dull	Sharp	Shooting	Aching	Throbbing
Other: _____					

10. Does your pain radiate to any of the following areas? □ Yes □ No

Left shoulder	Right shoulder
Left arm	Right arm
Left hand	Right hand
Left buttock	Right buttock
Left leg	Right leg
Left foot	Right foot

11. Are you experiencing any numbness/tingling in the following areas? □ Yes □ No

Left shoulder	Right shoulder
Left arm	Right arm
Left hand	Right hand
Left buttock	Right buttock
Left leg	Right leg
Left foot	Right foot

12. Please rate your average level of pain on a scale of 0--10 (0=no pain, 10=worst pain ever)

1	2	3	4	5	6	7	8	9	10

13. When are the symptoms worst?
Morning Afternoon Evening While sleeping While awake

14. When are the symptoms best?
Morning Afternoon Evening While sleeping While awake

15. Have you seen anyone else for this complaint?
None Chiropractor Medical Doctor Physical Therapist Specialist
Other: _____
Name of provider: _____

16. What happened to your condition as a result of treatment?
Resolved Unresolved Improved but not to acceptable level Worsened

17. Please list any drug allergies: _____

18. Do you have a history of any of the following?
Work related injury Motor vehicle accident Slip and fall accident

If yes, please list approximate dates and incidents:

Date: _____ Incident: _____
Date: _____ Incident: _____
Date: _____ Incident: _____
Date: _____ Incident: _____

19. Have you ever been hospitalized? □ Yes □ No

If yes, please list approximate dates and condition:

Date: _____ Condition: _____
Date: _____ Condition: _____
Date: _____ Condition: _____
Date: _____ Condition: _____

20. Have you had any surgeries? □ Yes □ No

If yes, please list approximate dates and surgery:

Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____

Lifestyle Information

1. Do you have any of the following symptoms?

General fatigue	Weakness fever	Loss of sleep	Chills	Weight change
Night sweats	Headaches	Dizziness	Fainting	Convulsions
Nervousness	Anxiety	Depression	Phobias	Memory loss
Mood swings	Hearing trouble	Ringing in ears	Pain in ears	Ear discharge
Vision trouble	Pain in eyes	Eye discharge	Nose/sinus pain	
Excessive drainage	Nose bleeds (chronic)	Nasal infections	Absence of smell	
Mouth sores	Bleeding gums	Enlarged glands	Absence of taste	
Abnormal taste	Tonsillitis	Difficulty swallowing		
Heat/cold intolerance	Sugar in urine	Goiter	Tremors	Skin rash
Redness of skin	Skin itching	Skin dryness	Eczema	Hair changes
Nail changes	Bruise easily	Chronic cough	Chronic wheezing	
Difficulty breathing	Swollen extremities	Blue extremities	Varicose veins	
Rapid heart beat	Chest pain	Heart palpitations	Heart murmur	
Decreased appetite	Increased appetite	Abdominal pain	Hemorrhoids Excessive	
Gas	Excessive vomiting	Excessive diarrhea	Excessive constipation	
Heartburn/indigestion	Prostate problems	Painful urination	Inability to hold urine	
Frequent urination	Bed-wetting	Irregular menstruation		
Painful menstruation	Abnormal vaginal bleeding		Sterility	
Impotence	Lumps in breast	Redness/itching of breast		
Dimpling of breast	Discharge from breast	Breast pain		

2. How would you rate your overall health? (1=poor, 10=excellent)

1 2 3 4 5 6 7 8 9 10

3. Please rate the importance for you to do the following: (1=not important, 10 = necessary)

Exercise	1	2	3	4	5	6	7	8	9	10
Eat right	1	2	3	4	5	6	7	8	9	10
Reduce stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Get off medication	1	2	3	4	5	6	7	8	9	10
Reduce pain	1	2	3	4	5	6	7	8	9	10
Increase mobility	1	2	3	4	5	6	7	8	9	10
Improve body's function	1	2	3	4	5	6	7	8	9	10
Improve posture	1	2	3	4	5	6	7	8	9	10
Increase energy	1	2	3	4	5	6	7	8	9	10
Improve sleep	1	2	3	4	5	6	7	8	9	10
Have a healthy family	1	2	3	4	5	6	7	8	9	10
Live an optimal life	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10

Other _____

4. What are you currently doing to improve your health and wellness?

_____

_____

5. What are some of your current health goals?

_____

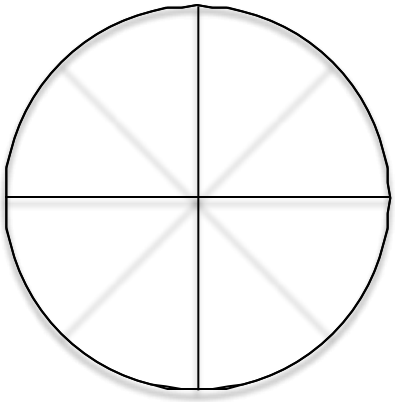
_____

6. Wellness is a balance of many factors. Starting in the center, color in your level of satisfaction in the following areas:

Career

Physical Environment

Money



Family/Friends

Health

Personal Growth

Fun/Recreation

Love/Romance

Signature: _____ Date: _____

The best investment you can make is to invest in your health.