CHIROPRACTIC INTAKE

Name:_____ Date:_____

Main Symptoms:_____

_____

Did the symptoms start:

- suddenly?
- gradually?_____

Type of pain (sharp, dull, aching, intermittent, any radiating pain or numbness, etc):_____

_____

What have you been doing for it?_____

What type of treatment have you had for this condition?_____

Is there anything that:

- relieves the pain?
- aggravates the pain?_____

Have you ever injured this area before? If so, describe the injury:_____

_____

Any x-rays taken?_____

Other symptoms:_____

_____

Are you taking any medications, including over-the-counter medications? If so, please list them below:_____

_____

Family Doctor:_____ Phone: _____

Childhood illnesses:_____

Accidents:_____

Allergies:_____

_____

Surgeries/hospitalizations:_____

_____

Stress factors currently in your life?_____

_____

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