Absolute
Chiropractic & Massage

Patient Intake Form

Date:_____

PERSONAL HISTORY

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Birth Date:_____ Age:_____ Sex: ____M ____F

Cell Phone #:_____ Email:_____

Circle one: Married Single Widowed Divorced Separated

Business Employer:_____ Type of Work:_____

Business Phone:_____ Who referred you to this office:_____

Name and Number of Emergency

Contact:_____Relationship:_____

CURRENT HEALTH CONDITION

Reason for visit:_____

Other Doctors seen for this condition: ____Yes ___No Who?_____

When did this Condition begin?_____ Has this condition occurred before? ___Yes ___No

Is Condition: ___Job Related ___Auto Accident ___Home Injury ___Fall

___Other:_____

Date of Accident:_____ Time of Accident:_____

Have you made a report of your Accident to your Employer: ___Yes ___No Insurance Company ___Yes ___No

Current Medications

_____

_____

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Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had:

___Influenza
___Pneumonia
___Rheumatic Fever
___Polio
___Tuberculosis
___Whooping Cough
___Anemia
___Measles
___Mumps
___Small Pox
___Chicken Pox
___Diabetes
___Cancer
___Heart Disease
___Thyroid
___Pleurisy
___Arthritis
___Epilepsy
___Mental Disorders
___Lumbago
___Eczema

Check any of the following you have had in the past 6 months:

Musculo-Skeletal:

___Low Back Pain
___Pain between Shoulders
___Neck Pain
___Arm Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficulty Chewing/Clicking Jaw
___General Stiffness

Nervous System:

___Nervous
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Fainting
___Convulsions
___Cold/Tingling Extremities
___Stress

General:

___Fatigue
___Allergies
___Loss of sleep
___Fever
___Headaches

Genito Urinary:

___Bladder trouble
___Painful/Excessive Urination
___Discolored Urine

Gastro-Intestinal:

___Poor/Excessive Appetite
___Excessive Thirst
___Frequent Nausea
___Vomiting
___Diarrhea
___Constipation
___Hemorrhoids
___Liver Problems
___Gall Bladder Problems
___Weight Trouble
___Abdominal Cramps
___Gas/Bloating After meals
___Heartburn
___Black/Bloody Stool
___Colitis

C-V-R:

___Chest Pain
___Short Breath
___Blood Pressure Problems
___Heart Problems
___Stroke
___Lung Problems/Congestion
___Varicose Veins
___Ankle Swelling

EENT:

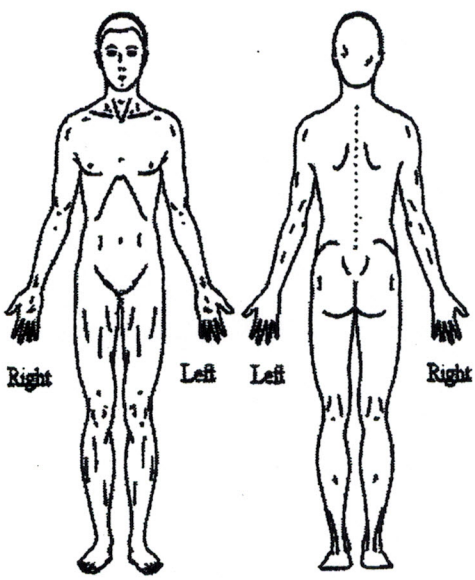
___Vision Problems
___Dental Problems
___Sore Throat
___Ear Aches
___Hearing Difficulty
___Stuffed Nose

Male/Female Code:

___Menstrual Irregularity
___Menstrual Cramps
___Vaginal Pain/Infection
___Breast Pain/Lumps
___Prostate/Sexual Dysfunction

Females Only:

When was your last period?_____
Are you Pregnant? ___Yes ___No



Please indicate on the diagram the area of your discomfort.