FALL RIVER
COLLABORATIVE HEALTH CARE

Chiropractic Intake Initial

Personal Information

Name: _____
Last Name First Name Middle Initial Pronouns (He/She/They)

DOB: _____
Year Month Day Height Weight

Address: _____
Street City Postal Code

Phone Number: _____
Home Cell Work

Occupation: _____ Employer: _____

Medical Doctor: _____ Health Card Number: _____

Emergency Contact (Name and Number) _____

How did you hear about our office?
( ) Patient Refferal ( ) Road sign ( ) Google Search ( ) Social Media ( ) Another Practitioner ( ) Other

If other, tell us how! _____

What is the main reason for your visit today? _____

Describe the onset of your symptoms: _____

How long have you had these symptoms/pain? _____

How would you describe this pain or symptoms?
( ) Aching ( ) Stabbing ( ) Shooting ( ) Numbness ( ) Tingling ( ) Other

If other, explain: _____

Is this pain constant or intermittent? _____

Is there a time of day that the pain seems to be at its worst?
( ) Morning ( ) Afternoon ( ) Evening ( ) Nighttime ( ) While sleeping ( ) During/After Activities

Is there a certain position or movement that makes the pain worse?
( ) Sitting ( ) Standing ( ) Twisting ( ) Rest ( ) Lifting ( ) Walking ( ) Exercise/straining ( ) Any movement
( ) Other

If other, explain: _____

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Does anything relieve your symptoms?
( ) Rest ( ) Movement ( ) Stretching ( ) Ice ( ) Heat ( ) Topical lotions (Biofreeze, Voltaren, etc)
( ) NSAIDS (Tylenol, Advil, etc) ( ) Muscle Relaxants ( ) Other

If other, explain: _____

Have you had treatment for this condition I the past?
( ) Yes ( ) No

If yes, how long ago? _____

Are you experiencing shooting pain down your legs or arms?
( ) Yes ( ) No

If yes, explain: _____

Chiropractic History

Have you ever seen a Chiropractor before?
( ) Yes ( ) No

If yes, how long ago and who did you see? _____

General Health

List any Medications (Including birth control) and doses if possible:

_____

Do you smoke (Including marijuana and cigars)
( ) Yes ( ) No ( ) Casually (less than 1x week)

If yes, how much? _____

Do you drink alcohol?
( ) No ( ) less than 1 per month ( ) 1-2 per month ( ) 1-2 per week ( ) 3-7 per week ( ) >7 drinks/week

Do you exercise?
( ) No ( ) 1-2x per week ( ) 3-5x per week ( ) >5x

Sleep Quality
( ) Excellent ( ) Good ( ) Poor ( ) Other

If other, explain: _____

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Sleep Position
( ) Back ( ) Stomach ( ) Side ( ) Multiple ( ) Arms above head/under pillow ( ) Leg bent and rotated
( ) Pillow under legs ( ) Other

If other, explain: _____

Have you had any surgeries or hospitalizations?
( ) Yes ( ) No

If yes, explain: _____

Have you had any fractures or dislocations?
( ) Yes ( ) No ( ) unknown

If yes, where? List all: _____

Are you currently experiencing any of the following?
( ) Pain that wakes you from sleep ( ) Recent fever/infection ( ) Night Sweats
( ) Unexplained weight loss/gain ( ) Extreme fatigue ( ) Fainting/dizziness ( ) Numbness into face
( ) Shortness of breath ( ) Rashes or skin issues

Have you ever been diagnosed with cancer?

( ) Yes ( ) No ( ) Waiting results

If yes, explain area and treatment received: _____

Please explain any other health conditions you have: _____

Check if you have had any of the following:

Neuromuscular skeletal
( ) Headaches ( ) Grinding/clenching teeth ( ) Stiff neck ( ) Upper back pain ( ) lower back pain
( ) Swollen joints ( ) Numbness ( ) Tremors ( ) Scoliosis ( ) Osteo Arthritis ( ) Rheumatoid Arthritis
( ) Psoriatic Arthritis ( ) Osteoporosis ( ) Carpal Tunnel ( ) Other

If other, explain: _____

Skin/Allergies
( ) Allergies ( ) Bruise easily ( ) Psoriasis ( ) Eczema ( ) Rashes or irritation ( ) Shingles
( ) Fungal Infection ( ) Skin sensitivities ( ) Cancer

Cardiovascular
( ) Heart Attack ( ) High Blood Pressure ( ) Low Blood Pressure ( ) High cholesterol ( ) Angina ( ) Stroke
( ) TIA ( ) Blood clots ( ) Varicose veins ( ) Irregular Heart beat/murmur
( ) Bypass Surgery ( ) Clotting issues ( ) Hemophilia ( ) Pacemaker ( ) Other

If other, explain: _____
Respiratory
( ) Asthma ( ) COPD ( ) Emphysema ( ) Difficulty breathing ( ) Chronic cough ( ) Chest pain
( ) Wheezing ( ) Other

If other, explain: _____

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Digestive
( ) IBS ( ) Crohn's ( ) Colitis ( ) Diverticulitis ( ) Reflux ( ) Ulcers ( ) Food sensitivities ( ) Celiac ( ) Hernia
( ) Gall Stones ( ) Constipation ( ) Gas or bloating issues ( ) Diarrhea ( ) Nausea/vomiting ( ) Other

If other, explain: _____

Urinary
( ) Frequent Urination ( ) Inability to control urine ( ) Inability to full void ( ) Strong smell to urine
( ) Regular bladder/kidney infections ( ) Kidney Stones ( ) Prostate issues ( ) Other

If other, explain: _____

Reproductive
( ) Pregnant ( ) Miscarriage ( ) C-section ( ) Irregular or painful periods
( ) Pre, peri or post menopausal ( ) Infertility issues ( ) Endometriosis ( ) PCOD ( ) Testicular issues
( ) Prostate issues ( ) Vasectomy ( ) Other

If other, explain: _____

Mental Health
( ) Depression ( ) Anxiety ( ) OCD ( ) Seasonal Affective disorder ( ) Personality Disorder ( ) Suicidal
( ) Schizophrenic ( ) Other

If other, explain: _____

Ears, nose, throat
( ) Allergies ( ) Hay fever ( ) Ear infections ( ) Trouble swallowing ( ) Sinus congestion/infection
( ) Loss of smell ( ) Loss of hearing ( ) Strep throat ( ) Other

If other, explain: _____

Neurological
( ) Dizziness ( ) Loss of consciousness ( ) Vertigo ( ) Concussions ( ) Stroke ( ) TIA
( ) Visual disturbance ( ) Twitching ( ) Balance issues/clumsiness ( ) Speech difficulties ( ) Tremors
( ) Fainting ( ) Paralysis ( ) Bells palsy ( ) Multiple Sclerosis ( ) Seizures ( ) Other

If other, explain: _____

Other
( ) Diabetes ( ) Thyroid Issues ( ) HIV Positive ( ) Other STD ( ) Alcoholism ( ) Drug Addiction
( ) Fibromyalgia ( ) Chronic Fatigue Syndrome ( ) Chronic Pain Syndrome

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Please tell us about anything that you feel we need to know in regard to your health that we may have missed

_____

_____

Privacy Policy

We are committed to protecting the privacy of all individuals providing personal and medical information to us, including the data recorded by our patients in our system. Your information is stored on a remote server specifically protected for medical records. Your information entered is shared only with the clinic and medical information is kept confidential. Medical information is only visible to the practitioners of the clinic. Personal information will be entered into our system strictly for the use of keeping complete medical records and to be able to contact you directly. Your information will never be shared with outside parties. Medical information is only visible to the practitioners of the clinic.

Acceptance

( ) I Agree to the above Privacy Policy