EVOLUTION
INTEGRATIVE MEDICINE
Life in Balance

CHIROPRACTIC INTAKE FORM

GENERAL INFORMATION

Full Name : _____

Date Of Birth : _____/_____/_____ **Age** : _____

Address : _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Number : _____ **E-Mail** : _____

Status : ☐ Single ☐ Married ☐ Divorced ☐ Other

Gender : ☐ Male ☐ Female

Occupation : _____ **Are You A Retiree ?** : ☐ Yes ☐ No

How did you hear about us? : _____

Do you have Insurance? : ☐ Yes ☐ No

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Can leave medical information with them:** ☐ Yes ☐ No

Relationship : _____ **Cell Number** : _____

ACKNOWLEDGEMENTS & CONSENTS

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

_____ I instruct the health care practitioner to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the health care offered in this practice is based on the best available evidence.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and release on my behalf for seeking reimbursement from any involved third parties.

_____ I grant permission to be called to confirm or reschedule an appointment and to be send occasional cards, letters, emails, or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____ We will bill your insurance as a courtesy to you, coverage is not final until we have received payment from your insurance company. You are responsible for what insurance does not pay.

Disclaimer: Our healthcare professionals are licensed chiropractors and clinical nutritionists, not MDs or DOs. While they are trained to diagnose and treat health conditions, their services are not a substitute for medical care provided by MDs or DOs.

Patient Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

CHIROPRACTIC QUESTIONAIRE

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO WHEN?_____

PLEASE LIST YOUR TOP 3 CONCERNS

1. _____
2. _____
3. _____

USE THE BODY KEY BELOW TO INDICATE ON THE DIAGRAM WHERE YOU ARE EXPERIENCING THE FOLLOWING SYMPTOMS:

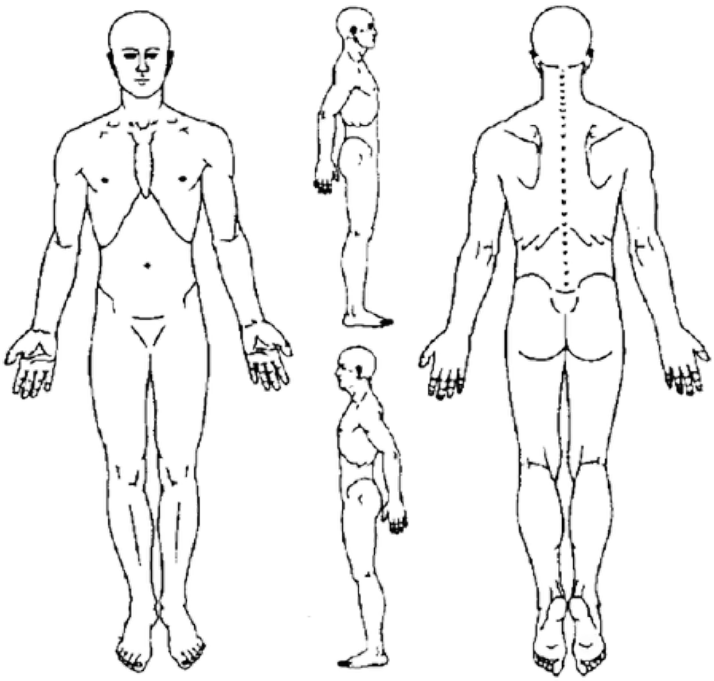
N = NUMBNESS

B = BURNING

S = STABBING

T = TINGLING

A = ACHE



DESCRIBE YOUR SYMPTOMS IN ORDER OF SEVERITY, WITH THE WORSE SYSMPTOM BEING #1.

_____

_____

ARE YOUR SYMPTOMS A RESULT OF: AUTO ACCIDENT_____ WORK RELATED ACCIDENT _____ OTHER _____

WHAT WAS THE DATE OF THE ACCIDENT. INCLUDE THE MM/DD/YYYY _____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? ☐ PAST YEAR ☐ PAST 5 YEARS ☐ OVER 5 YEARS ☐ NEVER

WHEN DID YOUR SYSMPTOMS BEGIN? INCLUDE THE MM/DD/YYYY _____

HOW DID YOUR SYMPTOMS BEGIN? _____

_____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS? **CIRCLE ONE.**

CONSTANTLY FREQUENTLY OCCASIONALLY INTERMITTENLY

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS? **CIRCLE ALL THAT APPLY**.

SHARP DULL NUMB SHOOTING BURNING TINGLING STABBING OTHER

CAN YOU PERFORM YOUR DAILY HOME ACTIVITIES? ☐ YES ☐ ONLY WITH HELP ☐ NO

CAN YOU PERFORM YOUR DAILY WORK ACTIVITIES? ☐ YES, ALL ☐ ONLY SOME ☐ NO

HAVE YOU HAD ANY X-RAYS, MRI, OR OTHER TESTS? IF YES, WHEN. _____

DO YOU WEAR ORTHOTICS? ☐ YES ☐ NO DO YOU HAVE ANY FOOT DISORDERS? ☐ YES ☐ NO

DO YOU HAVE COLD HANDS? ☐ YES ☐ NO DO YOU HAVE COLD FEET? ☐ YES ☐ NO

Patient Name: _____ Date: _____

GENERAL HEALTH

DO YOU FOLLOW ANY OF THE FOLLOWING EATING PLANS: *CHECK ALL THAT APPLY*.

☐ HIGH PROTEIN ☐ KETOGENIC ☐ NONE ☐ VEGETARIAN ☐ INTERMITTENT FASTING

☐ GLUTEN FREE ☐ PLANT BASED ☐ OTHER ☐ VEGAN ☐ COUNT MACRONUTRIENTS

DO YOU HAVE ANY ALLERGIES/SENSITIVITES OR DO YOU TRY TO AVOID ANY OF THE FOLLOWING?

☐ FISH ☐ LATEX ☐ SOY ☐ NIGHTSHADES ☐ NONE

☐ SHELLFISH ☐ MILK ☐ BEE PRODUCTS ☐ MUSHROOMS ☐ OTHER

☐ TREE NUTS ☐ GLUTEN ☐ RAGWEED ☐ PEANUTS

CHECK ALL THAT APPLY TO YOUR SEXUAL HEALTH.

☐ SEXUALLY ACTIVE ☐ LOW SEX DRIVE ☐ VAGINAL DRYNESS ☐ ABNORMAL DISCHARGE ☐ ERECTILE DYSFUNCTION

☐ NOT SEXUALLY ACTIVE ☐ REACH ORGASM ☐ CAN'T ORGASM ☐ PAIN WITH INTERCOURSE ☐ OTHER: _____

WOMEN ONLY: ARE YOU PREGNANT? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO **IF YES, HOW MUCH/OFTEN?** _____

DO YOU CONSUME ALCOHOL? ☐ YES ☐ NO **IF YES, FREQUENCY/AMOUNT** _____

DO YOU EXERCISE? ☐ YES ☐ NO **IF YES, HOW OFTEN/TYPE?** _____

DO YOU TAKE VITAMINS? ☐ YES ☐ NO **IF YES, WHAT TYPES?** _____

DO YOU DRINK WATER? ☐ YES ☐ NO **IF YES, HOW MANY GLASSES A DAY?** _____

HAVE YOU EVER HAD IV OR INJECTABLE VITAMIN THERAPY? ☐ YES ☐ NO **IF YES, WHEN?** _____

HAVE YOU HAD PROLONGED OR REGULAR USE OF NSAIDS (ADVIL, ALEVE, ETC), MOTRIN, ASPRIN? ☐ YES ☐ NO

HAVE YOU HAD PROLONGED OR REGULAR USE OF TYLENOL? ☐ YES ☐ NO

DO YOU HAVE REGULAR EXPOSURE TO ANY OF THE FOLLOWING: *CHECK ALL THAT APPLY.*

☐ MOLD ☐ DAMP ENVIRONMENTS ☐ CLEANING CHEMICALS ☐ STAGNANT OR STUFFY AIR

☐ PAINTS ☐ REGULAR CONTACT WITH SMOKERS ☐ OLD PAINT ☐ HEAVY METALS (LEAD, MURCURY, ETC)

☐ PESTICIDES ☐ RENOVATIONS ☐ HERBICIDES

☐ WATER LEAKS ☐ CARPETS OR RUGS ☐ AIRPLANE TRAVEL

☐ HARSH CHEMICALS (SOLVENTS, GLUES, ACIDS, ETC) ☐ ELECTROMAGNETIC RADIATION

IS THERE A HISTORY OF A SIGNIFICANT EXPOSURE TO ANY HARMFUL CHEMICALS? ☐ YES ☐ NO

IF YES: CHEMICAL NAME, LENGTH OF EXPOSURE, DATE. _____

DO YOU HAVE ANY PETS OR FARM ANIMALS? ☐ YES ☐ NO **IF YES, WHERE DO THEY LIVE?** ☐ INSIDE ☐ OUTSIDE ☐ BOTH

ARE YOU SEEING A PHYSICIAN FOR ANY REASON? ☐ YES ☐ NO

IF YES, EXPLAIN REASON: _____

HEALTH HISTORY - CHECK ONLY THOSE CONDITIONS THAT ARE APPLICABLE

_____ ALLERGIES
_____ ANEMIA
_____ ARTHRITIS (OSTEO)
_____ BOWEL PAIN
_____ DIARRHEA
_____ CONSTIPATION
_____ GAS/INDIGESTION
_____ BRAIN DISEASE
_____ SURGERIES

_____ OSTEOPOROSIS
_____ CHRONIC FATIGUE
_____ FIBROMYALGIA
_____ LUNG DISEASE
_____ ANGINA
_____ CANCER
_____ DIABETES
_____ EAR PROBLEMS
_____ OTHER

_____ FRACTURES
_____ STROKE
_____ KIDNEY
_____ LIVER
_____ HORMONAL
_____ MIGRAINES
_____ JAW PAIN
_____ RHEUMATISM

_____ HEART DISEASE
_____ WEIGHT PROBLEMS
_____ INSOMNIA
_____ DIZZINESS
_____ FREQUENT COLDS
_____ EYE PROBLEMS
_____ TENDONITIS
_____ THYROID

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING: INCLUDING DOSAGE & FREQUENCY.

_____

_____

_____