

Get In-Line Chiropractic

Patient Intake Form

Patient Info		Date	
Name		Email	
Address		Apt #	
City		State	ZIP
Phones - Home	Work	Cell	
Birth Date		Soc Sec #	Sex M F
Marital Status: M S D Sep W		# of Children:	Age Range of Children:
Drivers License #		Referred By	
Spouse's - Name		Birth Date	Phone
Employer /School		Occupation	
Address			
City		State	ZIP
Emergency contact - Name		Phone	
Health Insurance Info			
Carrier		Ins Co phone	
Address			
Policy #		Group #	
Patient Relationship to the insured Self Spouse Child Other			
If you are covered under another person's insurance.... Please complete			
Name of Insured			
Address of insured			
Phone of insured		Sex	Birth date
Insured's Employer			
Address			
Employer Phone		Plan Name	
Auto Accident Insurance		Policy Number	
Carrier			
Address			
City		State	ZIP Phone
Person to Contact...		Claim #	
Date of Accident		Patient Relationship to the insured Self Spouse Child Other	

Patient Self-Reported History

Reason For Visit:

Please tell us why you are here today: _____

When and How did this injury occur? _____

Have you seen any other Health Care Professional for this reason? Yes No If yes, Who and When?

Have you ever seen another Chiropractor before? Yes No If yes, Who and When?

Social History:

- Smoking Pack(s)/Day: _____
- Drinking Alcohol: _____
- Coffee Cups/Day: _____
- High Stress Reason: _____

Family History:

	Arthritis	Blood/ Heart	Cancer	Diabetes	Epilepsy	Kidney
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal GM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal GF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fraternal GM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fraternal GF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Exercise:

Cardio

- None
- Mild
- Moderate
- Daily

Resistance Training

- None
- Toning
- Strengthening
- Body Building

Cardio Length: _____

Medical History:

Please describe and conditions for which you are under the care of a physician: _____

Date of onset: _____ Duration of symptoms: _____

Doctor(s) involved, and their specialty: _____

Diagnostic tests used (X-ray, CT scan, MRI, etc.): _____

Current Treatment/Medication: _____

Past treatments, if any, and degree of success: _____

Medications:

- Antacids Antibiotics Antidepressants Antihistamines Anti-Inflammatories
- Birth Control Pills Blood Pressure Rx Cardiac/Heart Rx Diuretics Hormones
- Muscle Relaxers Pain Killers Parasite Medication Steroids Yeast/Fungal Rx

Please list any medication you take/have taken, for how long and why: _____

Surgeries/Hospitalizations:

- Appendectomy Arthroscopy Breast Implants Biopsies C-sections
- D&Cs Eye Surgery Implants/Prosthetics Laparoscopy Reconstructive
- Tonsils/Adenoids Other _____

Please describe the circumstances of any hospitalizations: _____

Patient: _____

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650-454-9558

Review of Systems

Reason For Visit:

Please check the “now” box for all conditions that you are now experiencing and mark the “PAST” box for any condition or symptoms experienced at any time in your life.

	▼	Now	▼	Past		▼	Now	▼	Past		▼	Now	▼	Past
General					G-I System					Neurological				
Unexpected Weight Loss		<input type="checkbox"/>		<input type="checkbox"/>	Gas		<input type="checkbox"/>		<input type="checkbox"/>	Seizures/Epilepsy		<input type="checkbox"/>		<input type="checkbox"/>
Unexpected Weight Gain		<input type="checkbox"/>		<input type="checkbox"/>	Heartburn		<input type="checkbox"/>		<input type="checkbox"/>	Stroke		<input type="checkbox"/>		<input type="checkbox"/>
Head					Indigestion		<input type="checkbox"/>		<input type="checkbox"/>	Tingling Sensation		<input type="checkbox"/>		<input type="checkbox"/>
Headache		<input type="checkbox"/>		<input type="checkbox"/>	Ulcers		<input type="checkbox"/>		<input type="checkbox"/>	Numbness		<input type="checkbox"/>		<input type="checkbox"/>
Dizziness		<input type="checkbox"/>		<input type="checkbox"/>	Vomiting/Nausea		<input type="checkbox"/>		<input type="checkbox"/>	Weakness		<input type="checkbox"/>		<input type="checkbox"/>
Head Trauma		<input type="checkbox"/>		<input type="checkbox"/>	Abdominal Pain		<input type="checkbox"/>		<input type="checkbox"/>	Difficulty Walking		<input type="checkbox"/>		<input type="checkbox"/>
Fainting		<input type="checkbox"/>		<input type="checkbox"/>	Diarrhea		<input type="checkbox"/>		<input type="checkbox"/>	Poor Coordination		<input type="checkbox"/>		<input type="checkbox"/>
Blacking Out		<input type="checkbox"/>		<input type="checkbox"/>	Constipation		<input type="checkbox"/>		<input type="checkbox"/>	Muscle/Bone				
Eyes					Blood in Stool		<input type="checkbox"/>		<input type="checkbox"/>	Joint Pain		<input type="checkbox"/>		<input type="checkbox"/>
Change in Vision		<input type="checkbox"/>		<input type="checkbox"/>	Hemorrhoids		<input type="checkbox"/>		<input type="checkbox"/>	Stiffness		<input type="checkbox"/>		<input type="checkbox"/>
Cataracts		<input type="checkbox"/>		<input type="checkbox"/>	Gall Bladder Disease		<input type="checkbox"/>		<input type="checkbox"/>	Muscle Ache		<input type="checkbox"/>		<input type="checkbox"/>
Light Sensitivity		<input type="checkbox"/>		<input type="checkbox"/>	Liver Disease		<input type="checkbox"/>		<input type="checkbox"/>	Arthritis		<input type="checkbox"/>		<input type="checkbox"/>
Flashes in Vision		<input type="checkbox"/>		<input type="checkbox"/>	G-U System					Bone Pain		<input type="checkbox"/>		<input type="checkbox"/>
Spots in Vision		<input type="checkbox"/>		<input type="checkbox"/>	Difficulty Urinating		<input type="checkbox"/>		<input type="checkbox"/>	Fractures		<input type="checkbox"/>		<input type="checkbox"/>
Mouth					Pain Urinating		<input type="checkbox"/>		<input type="checkbox"/>	Dislocations		<input type="checkbox"/>		<input type="checkbox"/>
Bleeding Gums		<input type="checkbox"/>		<input type="checkbox"/>	Blood in Urine		<input type="checkbox"/>		<input type="checkbox"/>	Conditions				
Cold Sores		<input type="checkbox"/>		<input type="checkbox"/>	Incontinence		<input type="checkbox"/>		<input type="checkbox"/>	Hypertension		<input type="checkbox"/>		<input type="checkbox"/>
Dentures		<input type="checkbox"/>		<input type="checkbox"/>	Foul Odor of Urine		<input type="checkbox"/>		<input type="checkbox"/>	Diabetes		<input type="checkbox"/>		<input type="checkbox"/>
Sore Throat		<input type="checkbox"/>		<input type="checkbox"/>	Increased Urination		<input type="checkbox"/>		<input type="checkbox"/>	Thyroid Condition		<input type="checkbox"/>		<input type="checkbox"/>
Jaw Pain		<input type="checkbox"/>		<input type="checkbox"/>	Decreased Urination		<input type="checkbox"/>		<input type="checkbox"/>	Heart Condition		<input type="checkbox"/>		<input type="checkbox"/>
Changes in Taste		<input type="checkbox"/>		<input type="checkbox"/>	Urinary Infection		<input type="checkbox"/>		<input type="checkbox"/>	Rheumatic Arthritis		<input type="checkbox"/>		<input type="checkbox"/>
Hoarseness		<input type="checkbox"/>		<input type="checkbox"/>	Genital Infection		<input type="checkbox"/>		<input type="checkbox"/>	Rheumatic Fever		<input type="checkbox"/>		<input type="checkbox"/>
Nose					Vascular System					Arthritis		<input type="checkbox"/>		<input type="checkbox"/>
Nosebleeds		<input type="checkbox"/>		<input type="checkbox"/>	Chest Pain		<input type="checkbox"/>		<input type="checkbox"/>	Osteoarthritis		<input type="checkbox"/>		<input type="checkbox"/>
Sinus Problems		<input type="checkbox"/>		<input type="checkbox"/>	Palpitations		<input type="checkbox"/>		<input type="checkbox"/>	Glaucoma		<input type="checkbox"/>		<input type="checkbox"/>
Lungs					Ankle Swelling		<input type="checkbox"/>		<input type="checkbox"/>	Alcoholism		<input type="checkbox"/>		<input type="checkbox"/>
Difficulty Breathing		<input type="checkbox"/>		<input type="checkbox"/>	Cold Feet/Hands		<input type="checkbox"/>		<input type="checkbox"/>	Cancer/Tumor		<input type="checkbox"/>		<input type="checkbox"/>
Asthma		<input type="checkbox"/>		<input type="checkbox"/>	Leg Cramps		<input type="checkbox"/>		<input type="checkbox"/>	Polio		<input type="checkbox"/>		<input type="checkbox"/>
Pneumonia		<input type="checkbox"/>		<input type="checkbox"/>	Calf Pain		<input type="checkbox"/>		<input type="checkbox"/>	Parkinson’s		<input type="checkbox"/>		<input type="checkbox"/>
Wheezing		<input type="checkbox"/>		<input type="checkbox"/>	Varicose Veins		<input type="checkbox"/>		<input type="checkbox"/>	Multiple Sclerosis		<input type="checkbox"/>		<input type="checkbox"/>
Persistent Cough		<input type="checkbox"/>		<input type="checkbox"/>	Low Blood Pressure		<input type="checkbox"/>		<input type="checkbox"/>	Gout		<input type="checkbox"/>		<input type="checkbox"/>
Coughing Phlegm		<input type="checkbox"/>		<input type="checkbox"/>	High Blood Pressure		<input type="checkbox"/>		<input type="checkbox"/>	Anemia		<input type="checkbox"/>		<input type="checkbox"/>
Coughing Blood		<input type="checkbox"/>		<input type="checkbox"/>	Skin					Osteoporosis		<input type="checkbox"/>		<input type="checkbox"/>
Tuberculosis		<input type="checkbox"/>		<input type="checkbox"/>	Rash		<input type="checkbox"/>		<input type="checkbox"/>	High Cholesterol		<input type="checkbox"/>		<input type="checkbox"/>
Itching		<input type="checkbox"/>		<input type="checkbox"/>	Bruising		<input type="checkbox"/>		<input type="checkbox"/>	Migraines		<input type="checkbox"/>		<input type="checkbox"/>
Peeling		<input type="checkbox"/>		<input type="checkbox"/>	Brittle Nails		<input type="checkbox"/>		<input type="checkbox"/>	TIA’s		<input type="checkbox"/>		<input type="checkbox"/>
					Changes in Moles		<input type="checkbox"/>		<input type="checkbox"/>	Headache unlike any other you’ve ever experienced		<input type="checkbox"/>		<input type="checkbox"/>

For the Doctor - Impressions/Notes:
