



INSPIRE
chiropractic &
wellness spa

CLINIC INTAKE FORM

Date _____ How you heard about us _____
Name (Last) _____ (First) _____
Address _____ City _____ Zip _____
Phone: Home () _____ Work () _____
E-Mail address _____ Marital Status S M D Other _____
Birth date _____ Age _____ Sex M F Social Security # _____
Employer _____ Occupation _____
Name & Number of Emergency Contact _____ Relationship _____
Have you ever seen a Chiropractor before Y N Who _____

CURRENT HEALTH CONCERNS

Purpose of this appointment (please be specific)

Other Doctors seen for this condition: _____ MD _____ DC _____ DO _____ DDS _____ other

When did this condition begin? _____

Is this interfering with your: _____ Work _____ Sleep _____ Daily Routine

Has this condition occurred before: _____ Yes _____ No

Is condition: _____ Job Related _____ Auto Accident _____ Home Injury _____ Fall _____ Date of Accident

Major life changes now or recently _____

Rate your overall physical health: (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	Best					Worst					
Rate your overall emotional / mental health: (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	Best					Worst					
Rate your pain: (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No pain					Unbearable					

How long has it been since you have felt good? _____

Drugs you now take: _____ Nerve Pills _____ Pain Killers/Muscle Relaxers _____ Blood Pressure

Medications _____

List of surgeries (Include Year) _____

List significant accidents or injuries since childhood _____

Do you suffer from any other condition other than the one you are consulting us for? _____

Have you had or do you use any of the following:

- | | |
|--------------------------------------|-------------------|
| _____ Massage / Body work | _____ Acupuncture |
| _____ Emotional Therapy / Counseling | _____ Reflexology |
| _____ Physical Therapy | _____ Yoga |
| _____ Nutritional Counseling | |

Please Check All Present Symptoms:

HEAD

- Headache
 - Sinus Migraine
 - Forehead Temples
- Head feels heavy
 - Entire Head Back
- Loss of memory
- Light bothers eyes
- Blurred Vision
- Loss of taste
- Dizziness
- Loss of balance
- Loss of hearing
- Pain in ears
- Buzzing in ears

NECK

- Pain in neck
- Neck pain with movement
 - Forward Backward
 - Turn to Left Right
 - Bend to Left Right
- Pinched nerve in neck
- Muscle spasms in neck
- Grinding sounds in neck
- Arthritis in neck

SHOULDERS

- Pain in shoulder joint (R L)
- Pain across shoulders
- Bursitis (R L)
- Can't Raise Arm (R L)
 - Above shoulder level
 - Over head
- Shoulders (R L)
 - Tension
 - Pinched nerve
 - Muscle Spasms

ARMS & HANDS

- Upper arm pain (R L)
- Elbow pain (R L)
- Movement aggravated
- Tennis elbow (R L)
- Forearm pain (R L)
- Hand pain (R L)
- Finger pain (R L)
- Sensation of pins & needles
 - In arms In fingers
- Numbness in arms (R L)
- Numbness in fingers (R L)
- Fingers go to sleep
- Hands Cold
- Swollen joints in fingers
- Sore joints in fingers
- Loss of grip strength

MID-BACK

- Mid-Back pain
- Pain between shoulders
 - Sharp stabbing
 - Dull ache
- Pain from front to back
- Muscle spasms
- Kidney pain

CHEST

- Chest pain
- Shortness of Breath
- Pain around ribs
- Irregular heartbeat

ABDOMEN

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK

- Low back pain
 - Upper
 - Lower lumbar
 - Sacroiliac
 - Muscle spasms

PAIN IS WORSE WHEN

- Working Bending
- Lifting Coughing
- Stooping Standing
- Lying down Sitting
- Walking

PAIN IS RELIEVED

When _____

HIPS, LEGS, FEET:

- Buttocks pain (R L)
- Hip Joint pain (R L)
- Pain down leg
 - Front Side Back
- Pain down both legs (R L)
- Knee pain (R L)
- Leg/foot cramps (R L)
- Numbness in legs (R L)
- Feet (R L) Toes (R L)
- Feet feel cold

GENERAL

- Nervousness
- Depressed
- Fatigue
- Irritable
- Loss of sleep
 - Weight Loss Gain
- Coffee per day _____
- Tea per day _____
- Cigarettes per day _____
- Alcohol per day _____
- Diabetes
- Hypoglycemia
- Other _____
- _____