

FULL LEGAL NAME: _____

DATE: _____



New Patient Chiropractic Intake Form

Preferred name: _____ Date of birth: _____ Age: _____ Sex: Male / Female
 Are you pregnant or nursing? Yes / No

Healthcare Goals

Please provide us with one to three of your top healthcare goals you hope to accomplish with our care team at Freedom Health Center of Minnesota.

1.
2.
3.

Commitment towards making valuable changes 1-10 (10 being most): 1 2 3 4 5 6 7 8 9 10

History of Present Illness

Describe the symptoms that bring you into the clinic:

When did your symptoms described above start?

How did the symptoms you described above start?

Please describe where on your body the pain or other symptoms are located.

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
- Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp Dull Ache Numb Shooting Burning Tingling Other

How are your symptoms changing?

- Getting Better Not Changing Getting Worse

During the past 4 weeks, indicate the average intensity of your symptoms

- 0 (None) 1 2 3 4 5 (Distracting) 6 7 8 9  10 (Unbearable)

In the past 4 weeks, how much of the time has your condition interfered with your normal work (including both work outside the home and housework)?

FULL LEGAL NAME: _____

DATE: _____

- Not at all A little bit Moderately Quite a bit Extremely

During the past 4 weeks, how much of the time has your conditions interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time None of the time

In general would you say your overall health right now is.....

- Excellent Very Good Good Fair Poor

Who have you seen for your current episode of symptoms?

- No One Chiropractor Chinese Medicine Provider Massage Therapist Medical Doctor
 Doctor of Naturopathic Medicine Physical Therapist Other

What test have you had for your current episode of symptoms and when were they performed?

- X-rays CT Scan MRI Lab Work Other None

Have you had similar symptoms in the past?

- Yes No

If you marked yes to the above question, who did you see?

- No One Chiropractor Chinese Medicine Provider Massage Therapist Medical Doctor
 Doctor of Naturopathic Medicine Physical Therapist Other

Brief Health History

Have you experienced any of the following in the past 4 weeks?

- Fever Chills Sweats Loss of appetite Fatigue Weakness Sleep disorder
 Diabetes None of these

Have any of the following family members (mother, father, sibling, grandparent, or child) been diagnosed with any of the below? Please indicate which member(s) in the notes.

- Cancer
 Diabetes
 Heart disease or high blood pressure
 Thyroid issues
 Mental health issues
 Digestive issues
 Autoimmune issues
 Other
 Family history unknown or no known family history

Do you have any allergies? If yes please indicate what they are and the reaction you have.

What medications have you taken in the past month? (Please provide name, dosage and frequency)

FULL LEGAL NAME: _____

DATE: _____

What supplements have you taken in the past month? (Please provide name, dosage and frequency)

Sleep: Average bed time: _____ Average wake time: _____ Sleep satisfaction 1-10 (10 being most): _____
I struggle with: falling asleep staying asleep night terrors snoring grinding teeth unrested

Energy: Rate your average energy 1-10 (10 being most): 1 2 3 4 5 6 7 8 9 10

Energy level is affected by: _____

Exercise: Activity type: _____

Other hobbies you enjoy: _____

Frequency of activity: _____ days/week

Duration of activity: _____ minutes

Intensity: low moderate vigorous

Do you consume caffeine? YES / NO If yes, how much and how often? _____

Do you consume alcohol? YES / NO If yes, how much and how often? _____

Do you use tobacco? YES / NO If yes, how much and how often? _____

Do you use recreational drugs? YES / NO If yes, how much and how often? _____

Any history of substance abuse? YES / NO - If YES, please specify: _____

Past Medical History

Current Weight: _____ Weight one year ago: _____ Ideal weight: _____ Current Height: _____

Have you been diagnosed with any conditions by other providers (examples: high blood pressure, diabetes, cancer, neuropathy, heart failure, seizure disorder, headaches, heart murmur, etc.)? Please provide any details you can about the conditions you list.

DATE	PREVIOUS DIAGNOSIS	OUTCOME/TREATMENT

Have you had any major surgeries or injuries? Please provide details of the injury/surgery and approximate dates along with other details you can recall.

DATE	SURGERY, EVENT, HOSPITALIZATION	OUTCOME