Nature's Touch
NATUROPATHIC CLINIC

Chiropractic Intake Form

Name:_____Date_____

Date of birth :_____ (M/D/Y) Sex: F_____ M _____

Address:_____

_____

_____

EmailAddress:_____

Empower your Health with monthly health tips by Nature's Touch: YES____ NO_____

Telephone number:Home:_____Work:_____

May we leave messages or email relating to your visits? YES_____ NO_____

Emergency contact: Name:_____

Phone number:_____Relation:_____

**An accurate health history form is important to ensure a safe chiropractic treatment. If your health status changes in the future, please let me know. All information gathered is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

How did you hear about our Clinic?_____

If referred, who were you referred by:_____

Other health care providers you are seeing:

1._____

2._____

What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Occupation: _____ Patient's Marital Status: _____

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Patient Name: _____ Date: _____

Patient's Age: _____ Patient's Height: _____ Patient's Weight: _____

Please circle (O) any conditions or symptoms presently causing you problems.

Please check (√) those conditions or symptoms which have been a problem to you in the past.

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions / Seizures
Loss of Sleep
Numbness / Loss of Sensation
Tingling / Pins and needles
Nervousness
Loss of weight
Loss of Sleep / Insomnia
Memory problems
Focus / Concentration problems

MUSCLES & JOINTS
Stiff/achy Neck
Stiff/achy Back
Swollen Joints
Painful tailbone
Shoulder pain
Arm / Forearm pain
Elbow / Wrist / Hand pain
Hip / Knee pain
Ankle / Foot pain
Weakness or loss of strength
Arthritis
Fibromyalgia

EYES, EARS, NOSE & THROAT
Blurred vision
Double vision
Failing vision (one / both eyes)
Eye pain
Deafness
Earache
Ringing, buzzing, any noise in the ears
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Slurred or other speech problems
Difficulty swallowing

RESPIRATORY
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing
Shortness of breath
Bronchitis
Emphysema

CARDIOVASCULAR
Bleeding Disorder
High blood pressure
Low blood pressure
Stroke
Atherosclerosis
Phlebitis
Varicose Veins
Chronic congestive heart failure
Swelling of ankles
Poor circulation
Heart or blood disease
Myocardial Infarction / Heart Attack
Angina
Pacemaker

GENITOURINARY
Trouble urinating
Blood in urine
Urinary Tract / Kidney infection
Bed wetting
Prostate issues

G.U. FOR WOMEN
Painful menstruation
Excessive flow
Irregular cycle
Cramps or backache
Hot flashes / Menopause
Vaginal discharge
Swollen breasts
Lumps in breasts
Caesarian Section

Have you ever been on birth control pills? □ Yes □ No

# of pregnancies _____

# of children _____

SKIN
Rashes, itching
Bruise easily
Dryness
Boils
Hives / Allergies

GASTROINTESTINAL
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Acid Reflux / GERD
Nausea
Vomiting (with or without blood)
Stomach pain
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall bladder / Liver issues
Ulcer
Diabetes
Hernia

INFECTIONS
HIV / AIDS
Hepatitis
Tuberculosis
Sexually transmitted infections

Have you ever been diagnosed with cancer? □ Yes □ No

Are you currently a smoker or have you smoked in the past?
□ Yes □ No

Do you consume alcohol:
□ Daily □ Socially

Do you consume caffeine:
□ 1-3 cups/day
□ 3+ cups/day

Allergies:
_____

Other:
_____
_____

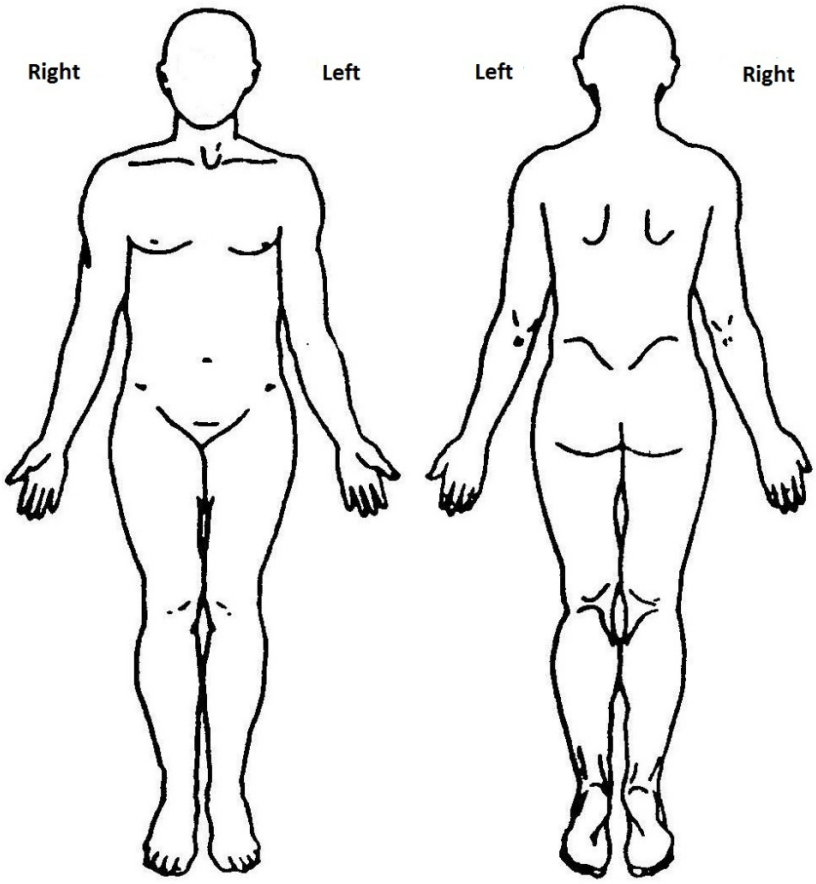
SYMPTOM DIAGRAM

Patient Name: _____ Date: _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

Symbols:

Dull & Aching	+ + + + + + + + + +	Stiff & Tight	Δ Δ Δ Δ Δ Δ Δ Δ Δ Δ
Numbness	≡	Pins and Needles	●●●●●● ●●●●●●
Burning	X X X X X X X X X X	Stabbing & Sharp	////



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