Chiropractic at Crossroads

Confidential Health Intake Form

Name: ______________________________ **Date**: ____________________

Were you referred you to us? No Yes By Whom? ____________________

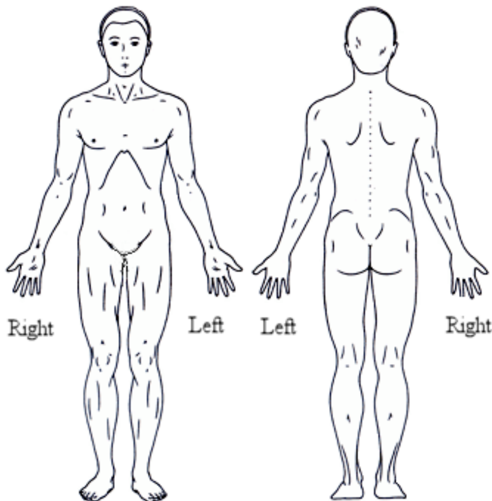
No: Walk-in / Internet / Yellow Pgs. ____________________

*** * * Please notify the receptionist if this is an SGI or WCB claim * * ***

✍ *In order to better assist you, please completely fill out this form* ✍

Current Problems

MARK AREAS OF PAIN BELOW



A.) Do you have pain/an injury today? YES NO
(Please mark on the picture to the left)

How did it happen? ____________________

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B.) Have you had pain like this in the past? ____________
Please explain: ____________________

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C.) Are there any other issues/concerns that bring you in today? ____________________

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Medical History

A.) In the last 6 months, have you received treatment from any of the following types of practitioners? (please circle)

- **Medical Physician**
- **Chiropractic Doctor**
- **Physiotherapist**
- **Massage Therapist**
- **Acupuncturist**
- **Naturopathic Doctor**
- **Other:** ____________________

What was (were) the reason(s) for above treatment: ____________________

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...PLEASE TURN OVER....

B.) Have you been diagnosed or treated by a physician for any of the following? (please circle)

Anemia	Constipation	Kidney Disorders
Anxiety	Depression	Multiple Sclerosis
Allergies	Diabetes	Neurological Condition
Arthritis	Difficulty Swallowing	Numbness / Tingling
Asthma / Lung Disorders	Digestive Disorders	Osteoporosis
Backaches / Bulged Disc	Dizziness	Psychiatric Condition
Bleeding Disorders / Clots	Epilepsy / Seizures	Sleep Disturbance
Blood Pressure	Fibromyalgia	Skin Conditions
Bruise Easily	Fracture	Thyroid Disease
Cancer	Heart Condition	Varicose Veins
Chronic Fatigue	TMJ (Jaw) Issues	Whiplash
Cholesterol	Headaches / Migraines	Other: _______________
Circulatory Problems	HIV / Autoimmune	____________________________
Concussion	Hepatitis / Liver Disease	____________________________

C.) Prescription or non-prescription drugs? ____

_______________________ Reason ____

D.) Herbs, Vitamins, Supplements, Special Diets? ____

Family History

Is there a history of any of these conditions in your immediate family?

Arthritis	Depression / Anxiety	Headaches / Migraines
Bleeding Disorders / Clots	Diabetes	Neurological / M.S.
Blood Pressure	Fibromyalgia	Osteoporosis
Cancer	Heart Condition	Other: ____________________

Doctor's Notes:

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