Chiropractic Intake Form

Please complete all sections before your appointment. This information helps us provide safe, effective care.

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Personal Information

Full Name *

Date of Birth *

Phone Number *

Email Address *

Home Address *

Sex *

◯ Male ◯ Female ◯ Other ◯ Prefer not to say

Occupation

Employer

Emergency Contact

Emergency Contact Name *

Relationship *

Emergency Contact Phone *

Chief Complaint

Tell us about the main reason for your visit today.

What is your primary reason for seeking chiropractic care? *

When did this problem begin? *

◯ Less than 1 week ◯ 1-4 weeks ◯ 1-3 months ◯ 3-6 months ◯ 6-12 months ◯ Over 1 year

How did the problem start? *

◯ Gradually ◯ Suddenly ◯ After an injury ◯ After surgery ◯ Unknown

How would you describe the pain? *

◯ Sharp ◯ Dull/aching ◯ Burning ◯ Throbbing ◯ Shooting/radiating ◯ Stiffness ◯ Numbness/tingling

Pain severity (0 = no pain, 10 = worst imaginable) *

◯ 0-1 ◯ 2-3 ◯ 4-5 ◯ 6-7 ◯ 8-9 ◯ 10

Is the pain constant or intermittent? *

◯ Constant ◯ Intermittent ◯ Only with certain movements

Pain Location

Select all areas where you experience pain or discomfort.

Where do you feel pain? (select all that apply) *

☐ Neck ☐ Upper back ☐ Mid back ☐ Lower back ☐ Left shoulder ☐ Right shoulder ☐ Left arm/hand
☐ Right arm/hand ☐ Left hip ☐ Right hip ☐ Left leg/foot ☐ Right leg/foot ☐ Headaches ☐ Jaw/TMJ

Aggravating & Relieving Factors

What makes the pain worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Twisting ☐ Lying down ☐ Coughing/sneezing
☐ Driving ☐ Exercise

What makes the pain better?

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Medication ☐ Massage ☐ Movement ☐ Change of position

Medical History

Please tick any conditions you currently have or have had in the past.

Do you have or have you ever had any of the following?

☐ Diabetes ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ Cancer ☐ Osteoporosis
☐ Arthritis (osteo or rheumatoid) ☐ Fibromyalgia ☐ Scoliosis ☐ Spinal surgery ☐ Fractures ☐ Disc herniation
☐ Sciatica ☐ Epilepsy/seizures ☐ Blood clotting disorder ☐ Autoimmune condition ☐ Depression/anxiety
☐ Chronic fatigue ☐ Pacemaker or implant

Are you currently pregnant? *

◯ Yes ◯ No ◯ Not applicable

Current Medications & Supplements

List all current medications (including dose and frequency)

List any supplements or herbal remedies

Do you have any allergies? (medications, latex, food, etc.)

Previous Treatment History

Have you received chiropractic care before? *

◯ Yes ◯ No

If yes, please provide details (practitioner, dates, reason, outcome)

Have you received any of the following treatments for this condition?

- [ ] Physiotherapy
- [ ] Massage therapy
- [ ] Osteopathy
- [ ] Acupuncture
- [ ] Cortisone injections
- [ ] Surgery
- [ ] Medication only
- [ ] None

Imaging History

Have you had any of the following imaging for this condition?

- [ ] X-ray
- [ ] MRI
- [ ] CT scan
- [ ] Ultrasound
- [ ] Bone density scan
- [ ] None

If yes, where and when were these performed? What were the results?

Work or Accident Related Injury

Is this condition related to a workplace injury? *

- ◯ Yes
- ◯ No

Is this condition related to a motor vehicle accident? *

- ◯ Yes
- ◯ No

If yes to either, please describe the incident (date, circumstances)

Lifestyle & Daily Activities

How would you describe your daily activity level? *

- ◯ Sedentary (desk job)
- ◯ Lightly active
- ◯ Moderately active
- ◯ Very active
- ◯ Physically demanding job

Which daily activities are affected by your condition?

- [ ] Sleeping
- [ ] Sitting at a desk
- [ ] Driving
- [ ] Household chores
- [ ] Childcare
- [ ] Exercise/sport
- [ ] Work duties
- [ ] Walking
- [ ] Personal care

How often do you exercise?

- ◯ Never
- ◯ 1-2 times per week
- ◯ 3-4 times per week
- ◯ 5+ times per week

What type of exercise do you do?

How would you rate your stress level?

- ◯ Low
- ◯ Moderate
- ◯ High
- ◯ Very high

How many hours of sleep do you get per night?

- ◯ Less than 5
- ◯ 5-6
- ◯ 7-8
- ◯ More than 8

Treatment Goals

What do you hope to achieve from chiropractic treatment? *

Declaration & Acknowledgement

¡ Please read the following statements carefully and tick to confirm your understanding.

- [ ] I confirm that the information provided on this form is accurate and complete to the best of my knowledge. I understand it is my responsibility to inform the clinic of any changes to my health.

- [ ] I understand that chiropractic assessment and treatment will be discussed with me before any procedures begin. I may ask questions at any time.

- [ ] I authorise this clinic to store my personal and health information in accordance with applicable data protection regulations (e.g. GDPR, HIPAA).

Patient Signature

Print Name: _____ Date: ___/___/_____