SPINE & JOINT CHIROPRACTIC REHAB CLINIC DMCC

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____

Describe Reason for Today's Visit: _____

_____

When did you first notice it? _____

Rate your pain: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
(best) (worst)

Have you seen another doctor for this? Yes ☐ No ☐ When? _____

Were x-rays or MRI performed? When? _____

Health Habits & Lifestyle:

Do you smoke? or Drink? _____

Do you exercise? _____

Medical Health History

List any medical condition you may have (i.e., allergies, pregnancy, heart disease, diabetes, cancer, high blood pressure, stroke, high cholesterol, etc.)

_____

List any medications (including prescription and over the counter)

_____

Have you ever had any surgeries? Yes ☐ No ☐

When and for what? _____

Do you have any implanted medical devices? (i.e., pacemaker, metal screws or rods, artificial hip, knee replacement, etc.)

_____

Signature: _____ Date: _____