Chiropractic Intake Form

Name: _____ Date of Birth: ___/____/____Height: _____ Weight:_____

What is your reason for seeking care? _____

How did you find Balance Chicago? _____

When did the problem begin? _____

Have you seen a doctor or been hospitalized for your condition in the past year? □ Yes □ No

Have you had any surgeries? □ Yes □ No If yes, what & when? _____

Is your injury the result of a fall? □ Yes □ No Have you fallen in the last 12 months? □ **Yes** □ **No**
If yes, how many falls?_____

Do you have pain? □ Yes □ No
Where is your pain located? _____
What makes it better? _____
What makes it worse? _____

On a scale of 1-10 please describe your stress level (1 = none, 10 = extreme) Work: _____ Personal: _____
On a scale of poor, good, excellent, describe your: Diet: _____ Exercise: _____ Sleep: _____ Health: _____

Please check all symptoms/conditions you have had:

□ Allergies	□ Anxiety	□ Asthma	□ Crohn's Disease
□ Cancer	□ Depression	□ Diabetes	□ Eating Disorder
□ Fibromyalgia	□ Hearing Problem	□ Heart Disease	□ High Blood Pressure
□ High Cholesterol	□ HIV/AIDS	□ Insomnia	□ Joint Injuries
□ Multiple Sclerosis	□ Osteoporosis	□ Parkinson's Disease	□ Pacemaker
□ Sleep Apnea	□ Seizures	□ Migraines	□ Rheumatoid Arthritis
□ Stroke	□ Vision Problems	□ Other: _____	

Medication List - Please Indicate Dosage:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Additional Questions:

Were you involved in any car accidents? □ **Yes** □ **No** _____
Did you have any serious falls/injuries as a child? □ **Yes** □ **No** _____
Do you drink alcohol? □ **Yes** □ **No** _____
Do you smoke cigarettes? □ **Yes** □ **No** _____
Do/did you take/use recreational drugs? □ **Yes** □ **No** _____
Is this a legal/workman's comp care? □ **Yes** □ **No** _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to consult, examine and treat me as necessary.

Patient Signature: _____ Date: _____

BALANCE CHICAGO

Chiropractor Signature: _____ Date: _____