REVIVE Chiropractic & Functional Medicine

Patient Name:_____Date:_____

Intake Form

Name:	
Birth date: _____/_____/_____	Age:
Address:	City/State/ZIP:
Preferred Phone: ( )	Home Phone: ( )
E-mail address:	
Employer:	Occupation:
Marital Status: ___Single ___Engaged ___Married ___Divorced ___Separated ___Widowed	
Spouse's Name:	Spouse's Occupation:
Children: Yes No	How Many:
Referral:	
Favorite Hobbies or Interests:	

Please select any reasons for pursuing chiropractic care:

___ I'm continuing care from another chiropractor.
___ I'm interested in wellness and natural health care for me and my family.
___ I'm concerned about my health and am looking for answers.
___ I have a specific condition that concerns me.

Please explain:

_____
_____
_____

Please sign, print, and date below to confirm all information has been accurately documented for.

Print patient name:_____

Sign patient/guardian:_____ **Date:**_____

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Diagnostic Form

Below is a list of health issues that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following health issues you have EVER had:

- □ Pneumonia
- □ Rheumatic Fever
- □ Arthritis
- □ Whooping Cough
- □ Heart Disease
- □ Eczema
- □ Mumps
- □ Smallpox
- □ Tuberculosis
- □ Cancer
- □ Thyroid Imbalance
- □ Influenza
- □ Pleurisy
- □ Diabetes
- □ Mental Disorders
- □ Measles
- □ Fibromyalgia
- □ Chicken Pox
- □ Epilepsy
- □ Anemia
- □ Heart Attack

Check any of the following health issues you have had in the PAST YEAR:

NERVOUS SYSTEM CODE

- □ Nervousness/anxiety
- □ Irritability/impatience
- □ Depression
- □ Attention deficit
- □ Stress
- □ Dizziness
- □ Forgetfulness
- □ Confusion
- □ Fainting
- □ Convulsions
- □ Cold Extremities
- □ Hemorrhoids
- □ Liver Problems

GASTROINTESTINAL

- □ Poor Appetite
- □ Excessive Appetite
- □ Excessive Thirst
- □ Excess Weight
- □ Frequent Nausea
- □ Gas or Bloating After Meals
- □ Heartburn
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Abdominal Cramps
- □ Gall Bladder Problems
- □ Diagnosed IBS, Crohn's, Diverticulitis, Colitis
- □ Black/Bloody Stool

MALE/FEMALE

- □ Menstrual Irregularity
- □ Menstrual Cramps
- □ Vaginal Pain/Infection
- □ Breast Pain/Lumps
- □ Significant Weight Loss
- □ Prostate Dysfunction
- □ Infertility Problems
- □ Other: _____

_____

GENERAL

- □ Headaches
- □ Migraines
- □ Loss of Sleep
- □ Allergies
- □ Neck Pain
- □ Mid Back Pain
- □ Low Back Pain
- □ Fatigue

Patient Name:_____Date: _____

GENITO-URINARY

□ Bladder Trouble
□ Discolored Urine

CARDIOVASCULAR/RESPIRATORY

□ Chest Pain
□ Asthma

EENT

□ Painful Urination
□ High Blood Pressure
□ Excessive Urination
□ Irregular Heartbeat
□ Stroke
□ High Cholesterol

The following family members have the same, similar problems, or major health issues:

□ Mother Issue(s):_____
□ Father Issue(s):_____
□ Sister Issue(s):_____
□ Brother Issue(s):_____
□ Spouse Issue(s):_____
□ Child Issue(s):_____

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Print patient name:_____

Sign patient/guardian:_____ **Date:**_____