TRANSFORMATION WELLNESS TEAM – Intake Form

Name (Last, First): _____How did you hear about us? _____
Address: _____ City, State: _____ Zip: _____
Phone: _____ Email: _____
Emergency Contact Name and Phone Number:_____
Date of Birth: _____ Preferred Pronoun _____
Have you ever received chiropractic care? No / Yes
Date of Last Visit: _____ How long were you under care for? _____
Primary reason for seeking chiropractic care? _____
Chief complaint: _____
How did this complaint begin? _____
When did this complaint begin? _____
Is this condition progressively worsening? No / Yes / Constant / Comes and goes
What is the quality of pain? Dull / Aching / Sharp / Shooting / Burning / Throbbing / Deep / Nagging / Other:
_____
Does this pain shoot/travel to other areas? No / Yes **To where? _____**
Are you experiencing any numbness or tingling? No / Yes **Where?_____**
What is the intensity/severity of pain? *(no pain)* 0 1 2 3 4 5 6 7 8 9 10 *(worst possible pain)*
How often is the complaint present; how long does it last?_____
Does anything aggravate the complaint? _____
Does anything alleviate the complaint? _____
Have you previously sought intervention for this complaint (treatment, medications, surgery, etc.)?
_____
_____
Is this condition the result of an accident? No / Yes **Explain: _____**
_____

Health History (Please include relevant dates)

Have you ever been involved in a motor vehicle accident? No / Yes **If yes, when? _____**
Previous illnesses: _____
Previous injuries/traumas: _____
Medications & reasons for taking: _____
_____
Previous surgeries: _____
Family Health History/ Associated health problems of relatives: _____
_____
How would you describe your current health? _____
How would you describe your family's health? _____
Exercise habits? _____ None / Moderate / Daily / Heavy
Work activity? _____ Sitting / Standing / Light labor / Heavy labor
Do you use any of the following? Tobacco / Alcohol / Caffeine / Milk **Frequency? _____**
Are you pregnant? No / Yes **Due Date: _____**

Which best describes your wellness goals? (Circle all that apply)
Treat a specific injury or ailment / Improve overall health / Maintain current wellness level / Achieve optimal health
Would you like more information about any of the following services? (Circle all that apply)
Massage / Acupuncture / Sauna / Petcare Services / Emotional Healing / Hypnosis / Life Coaching

I have read the above information and agree it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, in accordance with this state's statutes.

Signature: _____ Date: _____