20 N Fisher Park Way • Eagle, ID 83616
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PATIENT INTAKE FORM

Date:_____/_____/_____

PATIENT INTAKE OVERVIEW

First Name:______________________________Last Name:________________________Age:_______

Address:___________________________City:__________________State: Zip code: _____

Home Phone:__________________Cell Phone:___________________Work Phone: __________________

Email:____________________________________D.O.B. :_______________ ☐ Male ☐ Female

SS#:______________________Employer:____________________Occupation:______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Significant Other's Occupation:___________________Number of Children:________Ages of Children: ________

How did you hear about our office? ____

PURPOSE AND GOALS

What is your reason for seeking care? ____

When did this begin (if applicable)? ____

Are there any major surgeries and/or injuries we should know about? ______________________________

____

What is this affecting that is MOST important in your life? _____________________________________

Have you seen any other providers for this condition? ____

Have you seen a chiropractor before? ☐ Yes ☐ No

If yes, how long ago?__________Clinic/Doctor's Name: ______________________________________

What is your reason for the change (if applicable)? ____

What is your level of commitment to yourself and your health (1 = Low, 10 = High)? 1 2 3 4 5 6 7 8 9 10

Please explain: ____

What health goal, if accomplished, would have the greatest impact on your life? ___________________

____

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HEALTH CONCERNS

- ☐ Headaches
- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neck/Back Pain
- ☐ Irritability
- ☐ Light Sensitivity
- ☐ Memory Problems
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Fatigue/Sleep Issues
- ☐ Loss of Balance
- ☐ Pain in Arms/Legs
- ☐ Ringing in Ears
- ☐ Inability to Concentrate
- ☐ Stiffness
- ☐ Cold Hands/Feet
- ☐ Other: ______________________

Explain any boxes checked above or add additional concerns: ______________________

____

____

Is there anything else regarding your current condition the Doctor should know? ______________

____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other: ______________________

Explain any checked boxes above: ______________

____

____

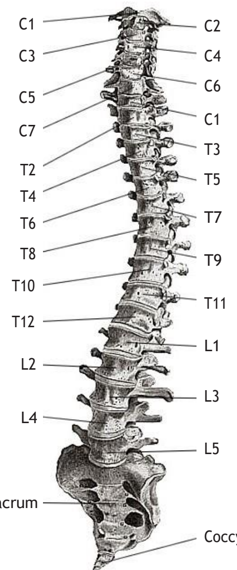
DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle concerns below or enter the information to the left.

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue/Sleep Problems
Head Colds
Vision Problems
Heart Conditions
High Blood Pressure
Difficulty Concentrating

____

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain/Numbness in Legs
Reproductive Problems



Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

VITAMINS/SUPPLEMENTS

- ☐ Multi-vitamin
- ☐ Vitamin D3
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ Other: ______________________

Additional Notes: ____

____

____

____

____

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HEALTH STATUS QUESTIONNAIRE

Rate based on frequency scale of 1 - 5. 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Regularly, 5 = Constantly

Your Physical Life	Nev	Rar	Occ	Reg	Con	Stress Evaluation	Nev	Rar	Occ	Reg	Con
Presence of physical pain	1	2	3	4	5	Family	1	2	3	4	5
Colds or flu	1	2	3	4	5	Significant life change	1	2	3	4	5
Chronic disease	1	2	3	4	5	Health	1	2	3	4	5
Ability to work out or engage in activity	1	2	3	4	5	Work/school	1	2	3	4	5
Tension, stiffness, lack of flexibility	1	2	3	4	5	Day-to-day stress	1	2	3	4	5
Fatigue or low energy	1	2	3	4	5	Finances	1	2	3	4	5
Mental/Emotional State	**Nev**	**Rar**	**Occ**	**Reg**	**Con**	**Life Enjoyment**	**Nev**	**Rar**	**Occ**	**Reg**	**Con**
Negative feelings	1	2	3	4	5	Recreational activities	1	2	3	4	5
Sleeping difficulties	1	2	3	4	5	Time devoted to hobbies	1	2	3	4	5
Depression/Anxiety	1	2	3	4	5	Experiences of well-being and relaxation	1	2	3	4	5
Moodiness, temper, angry outbursts	1	2	3	4	5	Interest in maintaining a healthy lifestyle	1	2	3	4	5
Being overly worried about small things	1	2	3	4	5						
Difficulty thinking or concentrating	1	2	3	4	5						

What else about your health do you feel is important for the doctor to know? ____________________

____

____

____

FAMILY HEALTH PROFILE

In addition to your health, we here at Legacy Chiropractic are also interested in the health and wellbeing of your loved ones. Please list any of their current health concerns below (i.e., high cholesterol, sports injuries, lack of mobility, financial stress, etc.):

Spouse/Partner:____________________

Parents:____________________

Siblings:____________________

Close Friends: ____________________

I agree that I have answered all questions on this form to the best of my knowledge and allow Dr. Brent Symes to examine and help me achieve optimal health.

____________________ Signature

____________________ Date

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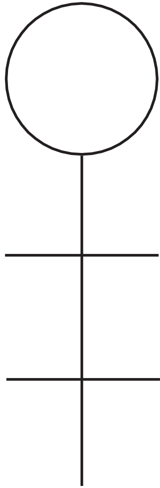
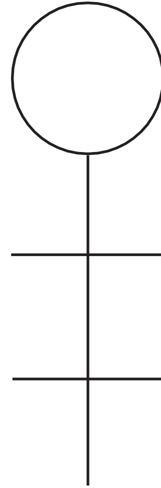


P - A POSTURE

Notes: ______________



LATERAL POSTURE

Notes: ______________

PALPATION

Cervical: 1 2 3 4 5 6 7   Thoracic: 1 2 3 4 5 6 7 8 9 10 11 12   Lumbar: 1 2 3 4 5

Notes: ______________

RANGE OF MOTION

Cervical:	Flexation ___	Extension ___	Rotation	R ____	L ____	Lat Flexion	R ____	L ____
Thoracic:	Flexation ___	Extension ___	Rotation	R ____	L ____	Lat Flexion	R ____	L ____
Lumbar:	Flexation ___	Extension ___	Rotation	R ____	L ____	Lat Flexion	R ____	L ____

ORTHOPEDIC TESTS

RESULTS

Notes: ______________