Desired Health Chiropractic
GET BETTER FASTER

Patient Health History
Minor Intake

PATIENT INFORMATION

Name	Today's Date	Birthdate	Age
Address	City	State	Zip
Home Phone	Mother's Name		
Cell Phone	Father's Name		
Work Phone	Number of Siblings		
E-mail	School/ Work		
Have you been to a chiropractor before? ☐ No ☐ Yes	Activities/ Sports		
Who referred you to our office?			
Emergency Contact	Phone #		
Name of Medical Doctor(s)			

- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices for Desired Health Chiropractic. I have read and understand them, or declined the opportunity to read them.
- I understand that the possible risks of chiropractic care are considered very rare, but may include strains, sprains, dislocations, injury to intervertebral discs, nerves or spinal cord, or cerebrovascular incident.
- I authorize the doctor or staff to render care as deemed appropriate for me and / or my child.

Patient / Guardian Signature (This represents a long term authorization for all occasions of service) **Date**

PRESENT COMPLAINTS

Briefly describe symptoms:

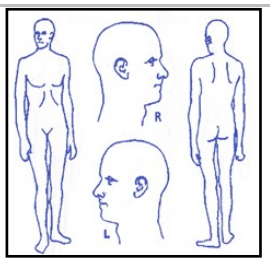
How did symptoms start?

When did symptoms start? How long has this been an issue?

What makes it better? What makes it worse?

Any previous treatment for this? Results:

Please mark **ALL** areas of concern



Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb ☐ Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same
☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates

Rate your pain on a scale of 1 (no pain) to 10 (unbearable pain): 1 2 3 4 5 6 7 8 9 10

Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Lifting

Have you had similar accidents or injuries before? ☐ No ☐ Yes

YOUR HEALTH GOALS

What specific health goals do you have? (Examples: Working out, vacation/trip, activities with family/kids)	**How will you know that you have reached this goal?** (Examples: Run a 5K, garden 3 times a week, sitting for more than 2 hours)
1.	**1.**
2.	**2.**
3.	**3.**

Desired Health Chiropractic
GET BETTER FASTER

General Health History
Minor Intake

GENERAL COMPLAINTS

Name Today's Date

Mark the conditions that apply to child:

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		Headaches			Sleeping Problems			Gall Bladder Trouble
		Migraines			Colic			Thyroid Problems
		Vision Problems			Easy Bruising			Liver Disease
		Light Bothers Eyes			Ear Problems			Kidney Problems
		Asthma			Ear Infections			Urinary Problems
		Allergies			Dental Problems			Digestive Problems
		Diabetes			Medication Side Effects			Heart Problems
		Muscle Aches			Tension / Irritability			Temper Tantrums
		Trouble Walking			Depression			ADHD
		Other _____			Other _____			Other _____

Current Height: Current Weight:

List any posture, movement, or growth concerns:

List any other health/developmental concerns:

List any medications being taking:

Number of courses of Antibiotics in the last 6 months:

Name of Pediatrician and other Doctors:

List any complications during pregnancy/delivery:

Has any Doctor advised you to "Go to a Chiropractor ☐ No ☐ Yes Name:

PAST HISTORY

List any past auto collisions: Was any care received?

List any past falls, bumps, bruises: Was any care received?

List any past sport, recreational, or home injuries:

Please describe any past conditions and treatment received:

Please list any past hospitalizations and surgeries:

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Is there any other family history you want us to know?