Transformational Healing Universe Intake Form

Transformational Healing Universe

Name: _____ **Sex:** ☐ ☐ **M / F** **Date:** _____

Address: _____ **State:** _____ **Zip:** _____

Phone _____ **Email:** _____ **Date of Birth:** _____ **Age:** _____

Referred by: _____ **Social Security #** _____

Occupation: _____ **Employer:** _____

Have you ever recieved Chiropractic Care? Yes ☐ No ☐ If yes, when? _____

1. **Primary reasons for seeking chiropractic care:**

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. **Chief Complaint:** _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: ☐ dull ☐ aching ☐ sharp ☐ shooting ☐ burning ☐ throbbing ☐ deep ☐ nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:**

_____

_____

_____

4. **Past Health History:** _____

A. **Previous illnesses you've had in your life:** _____

_____

_____

B. **Previous injury or trauma:** _____

_____

Have you ever broken any bones? Which? _____

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C. **Allergies** _____

D. **Medications:**

Medication	Reasons for taking

E. **Surgeries:**

Date	Type of Surgery

F. **Females/Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? _____

5. **Family Health History:**

Associated health problems of relatives: _____

_____

Deaths in immedicate family:

Cause of parents or siblings death	Age at death

6. **Social and Occupational History**

A. **Level of Education:**

High School ○ Some College College Graduate Post Graduate Studies

B. **Job description:** _____

C. **Work Schedule:** _____

D. **Recreational activities:** _____

E. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):** _____

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

Parent or Guardian Signature _____ Date _____