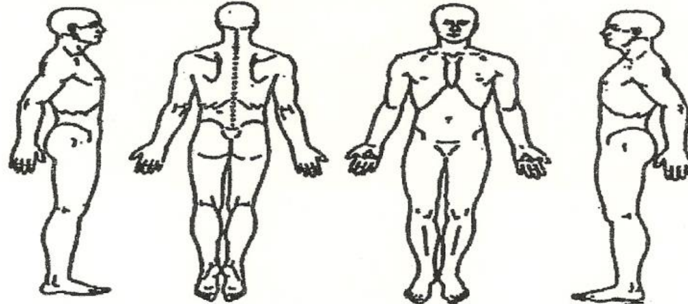
PRAIRIELANDS CHIROPRACTIC CLINIC, P.C., 300 W. BROADWAY, SUITE 712, COUNCIL BLUFFS, IA 51503 712-256-2561

Health Intake Form

FIRST NAME: ____________________ LAST NAME:_____________________

1. **Is today's problem caused by:** ☐Auto Accident ☐Workman's Compensation ☐Personal Injury ☐Trauma
2. **Indicate on the drawings below where you have pain/symptoms.**



3. **How often do you experience your symptoms?**
   ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
   ☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)
4. **How would you describe the type of pain?**
   ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse
   ☐ Sharp with motion ☐ Achy ☐ Shooting with motion ☐ Burning
   ☐ Stabbing with motion ☐ Shooting ☐ Electric like with motion ☐ Stiff
   ☐ Other: ____
5. **How are your symptoms changing with time?** ☐ Getting Worse ☐ Staying the same ☐ Getting Better
6. **Using a scale from 1-10 (10 being the worst), how would you rate your problem? (Please circle.)**
   0 1 2 3 4 5 6 7 8 9 10
7. **How much has the problem interfered with your work?**
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. **How much has the problem interfered with your social activities?**
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. **Who else have you seen for your problem?**
   ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
   ☐ ER physician ☐ Orthopedist ☐ Other:_________________________________
   ☐ Massage Therapist ☐ Physical Therapist ☐ No one
   Recent ☐ X-rays ☐ MRI ☐ CT ☐ Labwork taken Date taken: __________________
10. **How long have you had this problem?**____
11. **How do you think your problem began?**____
    ____
12. **Do you consider this problem to be severe?** ☐ Yes ☐ Yes, at times ☐ No
13. **What aggravates your problem?**____
    What helps your problem?____
14. **What concerns you the most about your problem; what does it prevent you from doing?**_______________
    ____
15. **Occupation:** ______________________________________ **Hobbies**: _________________________________
16. **How would you rate your overall health?** ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
17. **What type of exercise do you do?** ☐ Strenuous ☐ Moderate ☐ Light ☐ None
18. **Indicate if you have any immediate family members with the following:**
    ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problem ☐ Cancer ☐ ALS ☐ Other: _______________
19. **Have you had previous chiropractic?** ☐ Yes ☐ No **Results**: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
20. **Are you under the care of another physician/provider?** ☐ Yes ☐ No
    If yes, name of physician and facility: ____
21. **Have you ever been hospitalized?** ☐ Yes ☐ No **If yes, why and when**: __________________________
22. **List all surgical procedures you have had and when they occurred:** ________________________________
    ____
23. **List allergies:** ____
24. **List medications:** ____

    ____

25. For each of the conditions listed below, place a check in the Past or Present Column only if they apply.

Condition	Yes Past	Yes Current
Headaches	☐	☐
Neck Pain	☐	☐
Whiplash	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Herniated Disc	☐	☐
Shoulder Pain	☐	☐
Elbow/Upper Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Gout	☐	☐
Joint Pain/Stiffness	☐	☐
Arthritis	☐	☐
ALS	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Neuritis/Neuralgia	☐	☐
Fibrositis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Auto Immune Disease	☐	☐
Osteoporosis	☐	☐
Orthopedic Pins or Plates	☐	☐
Tumor, Cysts, Lipomas	☐	☐
Asthma/ Breathing Problems	☐	☐
Breathing Problems	☐	☐
Pneumonia	☐	☐
Chronic Sinusitis	☐	☐
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Attack	☐	☐
Chest Pains	☐	☐
Stroke	☐	☐
Peripheral Artery Disease	☐	☐
Blood Clots, Phleboliths	☐	☐
Hemophilia	☐	☐
Varicose/Spider Veins	☐	☐
Anemia	☐	☐
Raynaud's	☐	☐

Condition	Yes Past	Yes Current
Easy Bruising	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney/Bladder Disorders	☐	☐
Painful Urination	☐	☐
Loss of Bladder Control	☐	☐
Prostate Problems	☐	☐
Abnormal Weight Gain/Loss	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Irritable Bowel Syndrome	☐	☐
Crohn's	☐	☐
Hernia	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver/Gall Bladder Disorder	☐	☐
General Fatigue	☐	☐
High Stress/Anxiety/ Panic Attacks	☐	☐
Fibromyalgia	☐	☐
Thyroid Condition	☐	☐
Endocrine Disorders	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Poor Sleep / Insomnia	☐	☐
Tinnitis, Ear Ringing	☐	☐
Frequent Urination	☐	☐
Smoking/Tobacco Use	☐	☐
Drug/Alcohol Dependence	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Epilepsy	☐	☐
Dermatitis/Eczema/Rash	☐	☐
HIV/AIDS	☐	☐
For Females Only:		
Birth Control Pills	☐	☐
Hormonal Replacement	☐	☐
Pregnancy	☐	☐
IUD	☐	☐
OTHER:	☐	☐

26. Have you had significant past trauma (fractures, falls, motor vehicle accidents, etc.)? ☐ Yes ☐ No
Please explain. ____

27. Anything else pertinent to your visit today? ____

28. Questions/Concerns for us to discuss: ____

Patient Signature: ______________________________________ **DATE**: ______/_______/______

Parent/Guardian Signature if Patient is a Minor:________________________ **DATE**: ______/_______/______