



Five Star Chiropractic, LLC  
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## Human Intake Form

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Referred by/ how you found us: \_\_\_\_\_

### Medical History

Have you ever been to a chiropractor before? \_\_\_\_\_

Have you ever broken any bones? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_

Have you ever been in a car accident? \_\_\_\_\_

Have you ever had any surgeries? \_\_\_\_\_

Any preexisting health conditions? \_\_\_\_\_

Family health conditions? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

### Current Health Condition:

Reason for today's visit? \_\_\_\_\_

\_\_\_\_\_

Date of injury? \_\_\_\_\_

Quality of pain? \_\_\_\_\_

Pain scale (1-10) \_\_\_\_\_

Is it getting better or worse? \_\_\_\_\_

Does the pain travel / radiate? \_\_\_\_\_

Any numbness or tingling? \_\_\_\_\_

Any swelling / bruising? \_\_\_\_\_