Five Star Chiropractic, LLC
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FIVE STAR CHIROPRACTIC

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? _____