Patient Intake Form

19753 E. Pikes Peak Ct. | Ste. 101 and G101, | Parker, Colorado 80138 | 303-840-4991

How to save and submit this document:

To complete this form download the PDF and open the file in Adobe Acrobat. Adobe Acrobat is a standard program available on most computers. If you do not have Acrobat Reader it can be downloaded for free from Adobe at https://get.adobe.com/reader/. Email completed form **info@wolfchiro.com** **(make sure that the email subject line is new patient information).**

Patient Information

Date: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Marital Status: ☐ Yes ☐ No Spouse Name: _____ # of Children: _____

Home #: _____ Cell#: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring By: _____

Advertisement: ☐ Yes ☐ No Advertisement: _____

Referred Directory: ☐ Yes ☐ No Referred Directory: _____

Employer Information

Employed: ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor #: _____

Work Duties: _____

Complaint Information

Injury Occurred: ☐ Automobile ☐ Work ☐ Third Party ☐ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Frequency: ☐ Always ☐ Hourly ☐ Daily ☐ Occasionally

Interfere w/ Activities: ☐ Yes ☐ No Affected Sleep: ☐ Yes ☐ No

Missed Work: ☐ Yes ☐ No Unable to Work from: _____ Unable to Work till: _____

Affected Appetite: ☐ Yes ☐ No Explain: _____

Reduced Work: ☐ Yes ☐ No Explain: _____

Does it Worsen: ☐ Yes ☐ No Explain: _____

Weather Affects it: ☐ Yes ☐ No Explain: _____

Aggravates Condition: _____

Complaint Information (continued)

Improves Condition: _____

Received Treatment: ☐ Yes ☐ No Explain: _____

X-Rays Taken: ☐ Yes ☐ No Explain: _____

Same Condition Before: ☐ Yes ☐ No Date: _____ Practitioner: _____

Medical History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ☐ Yes ☐ No Date: _____ Explain: _____

_____

Chance Pregnant: ☐ Yes ☐ No Planning: ☐ Yes ☐ No

Medications: _____

Supplements: _____

Broken Bones: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No

Explain: _____

Sprains/Strains: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No

Explain: _____

Hospitalized: ☐ Yes ☐ No Explain: _____

Surgery: ☐ Yes ☐ No Explain: _____

Auto Accident: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No

Explain: _____

Struck Unconscious: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No

Explain: _____

Eating Disorder: ☐ Yes ☐ No Explain: _____

Stroke: ☐ Yes ☐ No Explain: _____

Family Health History: _____

_____

_____

_____

Patient Social

Alcohol: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Caffeine: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Diet Food Products: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Cannabis: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Energy Drinks, Red Bull, Monster etc: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Exercise: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Homemade Food: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Processed Food: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Soft Drinks: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Tobacco: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Water: ☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Health Checklist

- [ ] Allergies
- [ ] Alcoholism
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain
- [ ] Cold Extremities
- [ ] Constipation
- [ ] Cramps
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Loss of Memory
- [ ] Loss of Balance
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostrate Trouble
- [ ] Sciatica
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other _____

How to submit this document:

To complete this form download the PDF and open the file in Adobe Acrobat. Adobe Acrobat is a standard program available on most computers. If you do not have Acrobat Reader it can be downloaded for free from Adobe at https://get.adobe.com/reader/.

Once you have completed the form save the form to your computer. Once the form is saved open your email and create a new email addressed to **info@wolfchiro.com (make sure that the email subject line is new patient information).** Attache the saved pdf form to the email and add a brief note with your name and contact information. Once the form is attached to the email click send to submit the email.