SPRING LAKE PARK
CHIROPRACTIC

1611 County Hwy 10 NE | Spring Lake Park, MN 55432 | 763-784-1540

HEALTH RECORD INTAKE FORM

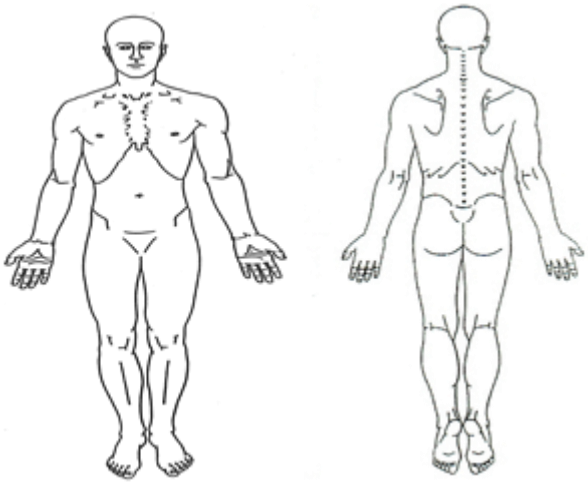
ABOUT YOU

☐ ADULT ☐ MINOR 0-17	Today's Date

Full Name First Last MI	Nickname
Address Street	City State Zip Code
Mobile Phone	
Home Phone	Work Phone
Email	
DOB	Gender ☐ Male ☐ Female
Employer	Position/Title
Marital Status ☐ Single ☐ Married	Spouse Name
Emergency Contact	Emergency Contact Day Phone
How did you hear about us? ☐ Insurer Network ☐ Internet ☐ Sign ☐ Friend/Family	If referred by a friend or family member, who may we thank?

REASON FOR YOUR VISIT

Describe the primary concern for your visit today:
When did it start?
How did this start?
Has this condition/concern interfered with ☐ work ☐ sleep ☐ daily routine
Have you seen other doctors for this condition/concern ☐ Yes ☐ No
Since onset, has this condition ☐ gotten worse ☐ stayed the same

HEALTH CONDITIONS (Check all past/current disease/conditions)		PAIN/CONCERN (Place a "✓" on any area of pain/complaint)
☐ severe or frequent headaches	☐ dizziness	
☐ frequent neck pain	☐ Irritability	
☐ lower back problems	☐ ADHD/ADD	
☐ arthritis	☐ sleeping disorders	
☐ digestive problems	☐ vision problems	
☐ pain between shoulders	☐ diabetes	
☐ pain in arms/legs/hands	☐ shingles	
☐ numbness	☐ kidney problems	
☐ allergies	☐ hepatitis	
☐ sinus problems	☐ rheumatic fever	
☐ asthma/difficulty breathing	☐ ulcers/colitis	
☐ high blood pressure	☐ tuberculosis	
☐ low blood pressure	☐ congenital heart defect	
☐ thyroid problems	☐ pacemaker	
☐ constipation	☐ cancer	
☐ diarrhea	☐ chemotherapy/radiation	
☐ ear problems	☐ Fever/Chills/Sweating	
☐ Change in appetite/thirst	☐ Easy bruising/bleeding	
☐ Unexplained weight changes	☐ Fainting/Weakness	
☐ Pain that wakes you up at night	☐ other _____	
☐ Pain that doesn't change w/ position		

List all surgeries:

List all past injuries/accidents:

Height	Weight	Blood Pressure

Females only - Are you pregnant, or could you be? ☐ YES ☐ NO

HEALTH HABITS

Have you been adjusted by a chiropractor? ☐ YES ☐ NO If yes, date of last visit? _____

Work activity ☐ sit often ☐ standing ☐ light labor ☐ heavy labor

Exercise program ☐ daily ___ days/week ☐ none
Recreational activities _____

Do you smoke ☐ YES ☐ NO _____ packs/day

Do you drink alcohol ☐ YES ☐ NO _____drinks/week

Do you drink coffee/tea/soda ☐ YES ☐ NO ____ ounces/day

Vitamins ☐ fish oil ☐ multivitamin/minerals ☐ calcium/magnesium ☐ vitamin D ☐ vitamin C ☐ other _____

Medications ☐ cholesterol medications ☐ stimulants ☐ tranquilizers
☐ muscle relaxers ☐ insulin ☐ pain killers
☐ blood pressure medication ☐ aspirin ☐ Ibuprofen ☐ Tylenol
☐ Other _____ (Attach medication list, if needed)