OM SPA
CHARLOTTE

New Patient Chiropractic Intake

Patient Information

Date: _____ SSN: _____ Birthday: _____

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

Sex: ◯M ◯F 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 Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ◯Yes ◯No Advertisement: _____

Referred Directory: ◯Yes ◯No Referred Directory: _____

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 Hist: _____

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 til: _____

Affected Appetite: ◯ Yes ◯ No Explain: _____

Reduced Work: ◯ Yes ◯ No Explain: _____

Does it Worsen: ◯ Yes ◯ No Explain: _____

Weather Affects it: ◯ Yes ◯ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯ Yes ◯ No Explain: _____

X-rays Taken: ◯ Yes ◯ No Explain: _____

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

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
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	☐ Venereal Disease

☐ Other: _____

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never					

Employer Information

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

Employer Address: _____

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

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Patient Signature: _____ Date: _____