

**BACK TO HEALTH WELLNESS CENTER  
NEW PATIENT INTAKE**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Phone \_\_\_\_\_ Cell Home Work (please circle)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Birth Date \_\_\_\_\_

SS # (last 4 digits) \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**YOUR HEALTH SUMMARY**

What is your chief complaint? Describe as clearly as possible.

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Please rate your current level of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (hospital level pain)

Have you sought other medical attention or done any home remedies for this issue?

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Have you ever seen a Chiropractor before? Yes No If yes, when? \_\_\_\_\_

Please list any medications or supplements you are taking: \_\_\_\_\_

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Please list any surgeries or hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Has this problem been getting better, worse, or staying the same? \_\_\_\_\_

\_\_\_\_\_

What activities make your condition worse? \_\_\_\_\_

Check all symptoms you are experiencing if they do not seem related to your current problem.

Headaches     Pins and Needles in legs     Neck Pain     Dizziness     Back Pain

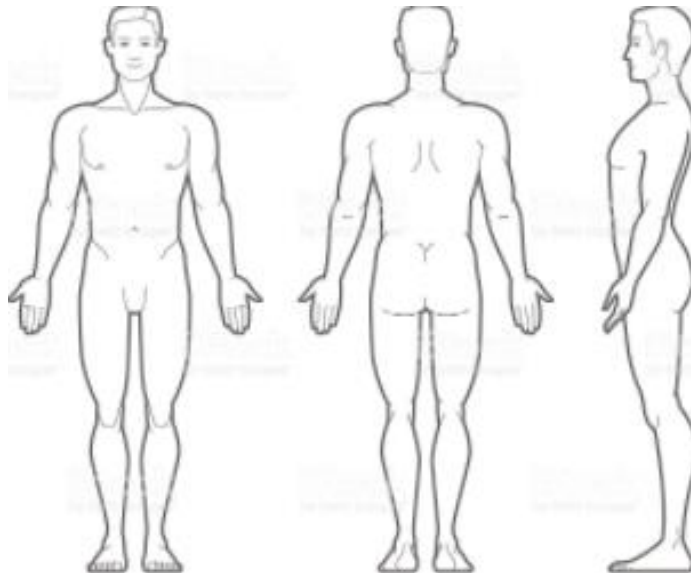
Pins and needles in arms     Loss of balance     Fatigue     Ringing in ears     TMJD

Numbness in fingers     Numbness in toes     Cold Feet     Depression     Tension

Menstrual irregularity     Cold Hands     Sleeping problems     Neck Stiffness

Heartburn     Vertigo     Migraines     Difficulty Urinating     Shoulder Pain

Please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off and on, when standing, when sitting, etc., etc.



Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal guardian/parent Signature: \_\_\_\_\_