

Intake Questionnaire Onalaska Family Chiropractic Wellness Center LLC

Name _____ What do you prefer to be called? _____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____

City, State, Zip _____ Birth date _____

Male/Female Age _____ SS# _____ Email _____

Occupation _____ Employer/address _____

Marital Status: Married Widowed Divorced Single Spouse's Name _____

Names of Children _____

Do you have insurance? Y N With what carrier? _____ Are you primary on that insurance? Y N

If not primary, please provide name and DOB of subscriber and relationship: _____

1. Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?

2. Science tells us your spine should be cared for regularly. Have you ever seen a chiropractor before today? Yes No
If so, how often did you get adjusted?
Frequently/only when you hurt/1 x monthly/infrequent

3. When was your last complete spinal examination including x-rays? _____ Never

4. Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem? Yes No What: _____

5. Over time, spinal misalignments will cause arthritis and degeneration, which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? Yes No

6. If your spine is out of alignment for a long time, it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? Yes No

7. Poor posture leads to poor health and early death. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. Stress will cause you to accelerate spinal damage. Rate your stress level over the last 3 months.
Calm/Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

9. Please check (and circle which side) any health symptoms or health complaints you are experiencing.

____ Neck pain Left/Right	____ Arm pain/Numbness L/R	____ Asthma	____ Thyroid
____ Upper Back Pain L/R	____ Leg pain L/R	____ Cancer	____ Allergies: _____
____ Mid-back pain L/R	____ Headaches/Migraines	____ Constipation	____ Other: _____
____ Lower-back pain L/R	____ Diabetes I/II	____ Menstrual pain	_____

10. Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (Use back if necessary)
1. _____ 2. _____ 3. _____

11. Please list any surgeries you have had. _____

12. Daily trauma, auto accident(s), and work injuries can cause serious spinal problems.
When was your most recent injury at home? _____ Car accident? _____ Slip or fall? _____

13. Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant? Yes No

14. Do you smoke? Yes No

15. Improper sleeping positions can cause spinal damage. What sleeping position do you sleep in: Back Stomach R Side L Side

16. Exercise level: Never, Infrequent, 1 2 3 4 5 6 7+ times per week

17. Are you? Right Handed Left Handed

18. Please list vitamins/supplements you take: _____

19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely?
 Yes No

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian): _____ Date: _____