When you have completed this form, please email it to tcfotsego@gmail.com or bring with you to your first visit.

Patient Intake Questionnaire

Name:____ DOB:___________________ Date:_______________________

Street Address:____ City:_____________________ State:_____________

Cell Phone:____________________________________ Email:____

Can we send you occasional texts and emails? Yes No Have you seen a chiropractor before? Yes No

Occupation:____________________________________ Employer:____

Referred by:____________________________________ Favorite Band:____

Emergency Contact → Name:________________________ Phone #:_____________________ Relationship:___________

Hobbies: ____

Chief Complaint/Reason for Visit:____

____ Date of Injury:_______________________

How did this injury occur:____

Describe your pain:____

Rate your pain on a 0 to 10 scale → _________ /10 now _________ /10 at best _________ /10 at worst

Aggravating Factors:__________________________________ Alleviating Factors:__________________________________

Previous treatment for this complaint:____

Home/self treatment:____

How does this injury affect Activities of Daily Living? i.e. dressing, hygiene, driving, sitting, working, getting up from chair or bed, exercising etc:____

Personal history of chief complaint:____

Previous Hospitalizations/Injuries/Illnesses:____

____

Current Medications:___________________________________ Supplements/Vitamins:________________________________

Family History of: Cancer Diabetes Heart Disease High Blood Pressure Stroke

____

Allergies:___________________________________ No. of Children & Ages: _____________________________________

Types of Exercise & Frequency:____

Sleep → Average hours/night:_________ Do you wake up rested? Yes No

Other:______________________________

Other Pertinent Information: ____

____