# South Austin Chiropractic

## Confidential Patient Information

Name_____ date _____
Sex: M/F Marital Status: S/M/D/W D.O.B._____ Age____
Phone: Work:_____Home:_____Cell:_____
Address_____City_____State____ZIP_____
Occupation_____ Spouse/Partner's Name_____
Hobbies_____
_____Email Address_____
Emergency contact:_____phone:_____
Have you been to a Chiropractor before? Yes/No
Name(s) of Chiropractor(s):_____
Who Referred you to our office?_____
Reason for consulting our office:_____
List your health concerns in order of importance.

| Health Concern | What have you tried to solve this concern? |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Are you more interested in: (a.) getting rid of symptoms (pain, fever, etc.)
or: (b.) correcting the cause ?
Do you understand that problems are usually still present and in need of correction even after the symptoms/pain have gone away? (circle Yes/No)
How committed are you to maintaining optimum health? (1-10)_____

Please circle any of the following that are part of your health picture (past or present)

| | | | |
|---|---|---|---|
| insomnia | skin condition | ear infection | digestive problems |
| depression | scoliosis | sleep apnea | heartburn |
| bed wetting | convulsions | nervousness | constipation |
| high blood pressure | epilepsy | asthma | diarrhea |
| heart trouble | concussion | dizziness | sinus trouble |
| diabetes | chemical dependence | infertility | back aches |
| headaches | fatigue | sleeping problems | numbness |
| mood swings | loss of smell | buzz/ringing ears | arthritis |
| irritability | problems urinating | hot flashes | allergies |
| menstrual pain | menstrual irregularity | loss of balance | sciatica |
| spinal fusion | spinal trauma | spinal surgery | spinal anomaly |

## Why this form is important:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

List any surgeries or operations and their date:

1. 3.
2. 4.

List any significant physical traumas (past) or physical stresses (present):

1. 3.
2. 4.

List all medications you are on and what they are for. Also list any other bio-chemical stresses:

1. 3.
2. 4.

List any significant emotional traumas (past) or emotional stresses (present):

1. 3.
2. 4.

How stressful is your life? (on a scale of 1 to 10)
1=no stress / 10=extreme stress
Occupational life_____ Personal life_____

## Any additional information you think would be helpful:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctors of Innate Potential Chiropractic and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct.

Patient's (Parent or Guardian's) Signature_____