Carmel Valley Chiropractic and Rehabilitation | Health Intake Form

Name:	City: _ Email: P	State: Occupatio	Zip: on:
(Need email to send Invoice/Bill)	_ Email: P	Occupation	on:
(Need email to send Invoice/Bill)	P		
		rimary Insured DOB:	Ins Type
	SCRIBE CURRENT PF	ROBLEM AND WHEN IT BEGA	N:
Current Complaint (How your 1 2 3 4 5 6		mark on picture with X where	e you have pain or symptom
How often are your symptoms 0-25% 26-50% 51-75 Have you had spinal X-rays, MI What areas were taken?	76-100% RI, CT Scan? Y/N		
Have you seen any doctor for the Have you ever seen a chiropract Please check all of the following that	ctor before? Y/N		
History of recent infection	Recent Trauma		
-	Prostate Problems	Surgeries/M	edications:
	Frequent Urination		
•	Pregnancies, # of b		
	Abnormal weight g		
	Epilepsy / Seizures	•	
	Upnepsy / Seizures Visual Disturbance		
	History of Low/Mid back pain		
	History of Neck pain		
Urinary Retention	Arthritis		•
•	· 	Hen	
Aortic Aneurysm	History of Alcohol		
•	History of Tobacco	use	
Osteoporosis			

Patient Signature: ______ Date: _____