Infinite Chiropractic Intake Form

Patient Name: _____ Date: _____

Medications: _____

_____

Supplements: _____

_____

Describe your symptoms: _____

_____

How long have you had these symptoms? _____

Frequency and length of occurrence: _____

Describe what it's like at its worst: _____

_____

How does that effect you at work? _____

_____

At home? _____

_____

How have you tried to treat the problem? (other doctors, etc.) And what was the outcome?

_____

_____

_____

Any history of:

- Hemophilia
- Steroid Shots _____ (last date)
- Cancer _____ (last date)
- Infections _____ (area)
  _____ (last date)
- Hair Loss/ Thinning
- Diabetes _____ (A1c)
- Antiphospholipid Syndrome
- Lymphedema
- Other?
  _____
  _____
- Alcohol Abuse
- Cigarette Smoking
- Low Platelets
- Hepatitis
- Heart Instability
- Anti-inflammatories _____ (date)
- Blood Thinners
- HIV
- Aging Skin/ Wrinkles