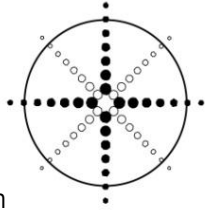


20210 76th Ave. W
Edmonds, WA 98026
www.myjourneychiro.com



J O U R N E Y

family chiropractic

PHONE: 425.712.9277
FAX: 425.775.5085
DATE: ___ / ___ / ___

PATIENT INTAKE OVERVIEW

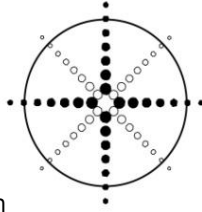
First Name: _____ Last Name: _____ Age: _____
Address: _____ City: _____ State: ___ Zip code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ D.O.B.: _____ Male Female
Employer: _____ Occupation: _____
Marital Status: Single Married Divorced Widowed Partnered
Significant Other's Occupation: _____ Number of Children: _____ Ages of Children: _____
How did you hear about our office? _____

PURPOSE AND GOALS

What is your reason for seeking care? _____
When did this begin (if applicable)? _____
Are there any major surgeries and/or injuries we should know about? _____

What is this affecting that is MOST important in your life? _____
What would you like to gain from chiropractic care? Resolve Existing Conditions Overall Wellness Both
Who is your primary care physician? _____
Date and reason for your last doctor visit? _____
Are you receiving care from any other health professionals? If yes, please name them and their specialty: _____

Have you seen a chiropractor before? Yes No
If yes, how long ago? _____ Clinic/Doctor's Name: _____
What is your reason for the change (if applicable)? _____
What is your level of commitment to yourself and your health (1 = Low, 10 = High)? 1 2 3 4 5 6 7 8 9 10
Please explain: _____
What health goal(s), if accomplished, would have the greatest impact on your life? _____



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MEDICATIONS

- Anxiety/Depression
- Blood Pressure
- Pain Narcotics
- Muscle Relaxers
- Other: _____
- Migraine/Headache
- Cholesterol
- ADD/ADHD
- Diabetes

Explain any checked boxes above: _____

VITAMINS/SUPPLEMENTS

- Multi-Vitamin
- Vitamin D3
- Vitamin B12
- Other: _____
- Fish Oil/Omega-3
- Probiotics
- Vitamin C

Explain any checked boxes above: _____

FAMILY HEALTH PROFILE

In addition to your health, we here at Journey Family Chiropractic are also interested in the health and wellbeing of your loved ones. Please list any of their current health concerns below (i.e., high cholesterol, sports injuries, lack of mobility, financial stress, etc.)

Spouse/Partner: _____

Parents: _____

Siblings: _____

Close Friends: _____

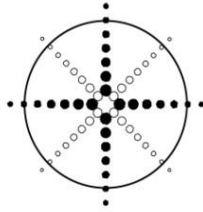
ADDITIONAL NOTES

I agree that I have answered all questions on this form to the best of my knowledge and allow Dr. Madison Allen to examine and help me achieve optimal health.

Patient Signature

Date

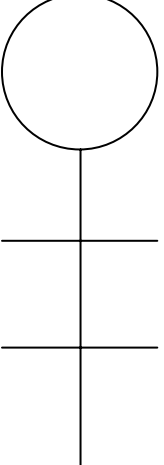
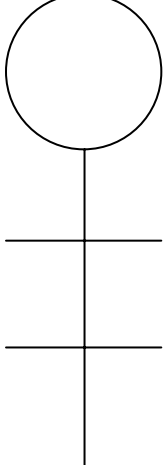
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	P-A POSTURE Notes: _____ _____ _____ _____ _____ _____ _____ _____ _____		LATERAL POSTURE Notes: _____ _____ _____ _____ _____ _____ _____ _____ _____
---	--	--	--

PALPATION

Cervical: 1 2 3 4 5 6 7 Thoracic: 1 2 3 4 5 6 7 8 9 10 11 12 Lumbar: 1 2 3 4 5

Notes: _____

RANGE OF MOTION

Cervical:	Flexation _____	Extension _____	Rotation R _____ L _____	Lat Flexion R _____ L _____
Thoracic:	Flexation _____	Extension _____	Rotation R _____ L _____	Lat Flexion R _____ L _____
Lumbar:	Flexation _____	Extension _____	Rotation R _____ L _____	Lat Flexion R _____ L _____

ORTHOPEDIC TESTS	RESULTS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Notes: _____

