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

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
- ☐ Migraine/Headache
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Pain Narcotics
- ☐ ADD/ADHD
- ☐ Muscle Relaxers
- ☐ Diabetes
- ☐ Other:____________________

Explain any checked boxes above:____________________

____

____

VITAMINS/SUPPLEMENTS

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

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:________________________

____
____
____
____
____
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____
____

LATERAL POSTURE

Notes:________________________

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____
____
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____

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:____

____
____