Goodyear Chiropractic

Welcome *v1.1*

11. W. Van Buren Avondale, Az 85323
(623)932.4060 (623)932.4417 fax

Name _____ Date of Birth _____

SSN _____ Gender Male Female

Address _____City _____ State ___ Zip ____

Home Phone _____ Cell _____ Other _____

Marital Status: Single Married Divorced Widow

Emergency Contact _____ Phone _____ Relation _____

Email _____

Do we have your permission to e-mail / text you No Yes _____

Initial

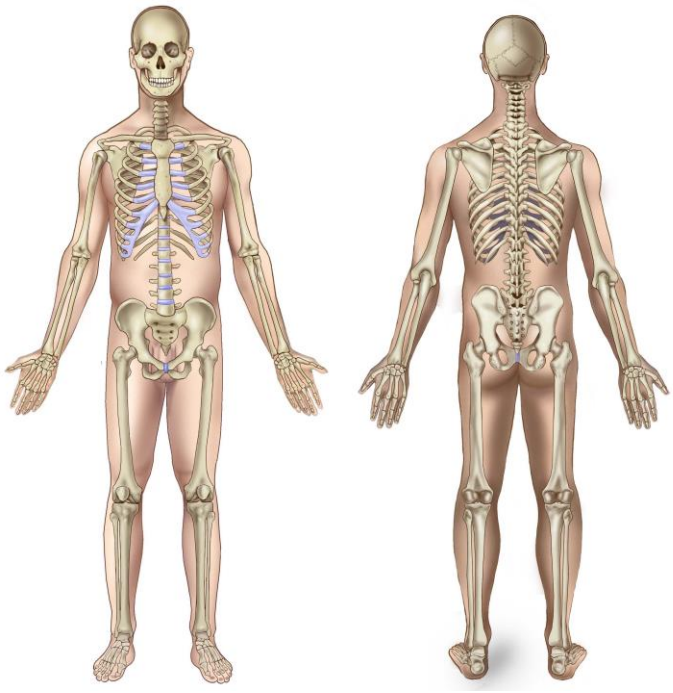
How did you hear about us? Thank you for being as detailed as possible.

- **Friend _____**
- **Internet:** Google Facebook Yelp **_____**
- **Drive-by Street sign**
- **Treated here before**
- **Massage Therapist**
- **News Paper:** West Valley View Buckeye Star **_____**
- **Other _____**

Goodyear Chiropractic

Patient Intake *v 1.1*

Mark Where You Are Having Symptoms



Circle Where You Are Having Symptoms

Neck Pain	Left / Right Arm Numb	Mid Back Pain
Low Back Pain	Left / Right Leg Numb	Left / Right Sciatica
Headache	Vertigo	Short Term Memory Loss
Left / Right Blurry Vision	Left / Right Ear Ringing	Left / Right Jaw Pain
Left / Right Shoulder Pain	Left / Right Elbow Pain	Left / Right Wrist Pain
Left / Right Hand Pain	Left / Right Arm Pain	Left / Right Arm Cuts/Bruise
Left / Right Hip Pain	Left / Right Knee Pain	Left / Right Ankle Pain
Left / Right Foot Pain	Left / Right Leg Pain	Left / Right Leg Cuts/Bruise
Left / Right Rib Pain	Chest Pain	Stomach Pain

Pain Level 3 4 5 6 7 8 9 10

Type Aching Sharp Cramping Radiating Stiff Spasm Burning Tight Tingling

Freq. Constant Frequent Worse in Morning Worse at night Worse in Afternoon

Which Activities Aggravate Your Condition

Neck Movement	Back Movement	Lifting
Reaching	Sitting	Walking
Standing	Bending	Yard Work
House Chores	Coughing	Sneezing
Sex	Other:	

Daily Habits Smoking 0 1 2 3 Alcohol 0 1 2 3 Exercise 0 1 2 3

0 =none 1 = a little 2= moderate 3 = a lot

Dominant Hand Left Right

How long have you had this Condition _____

Has this happened before Yes No **How Often** _____

Was this due to a Trauma Yes No **Details** _____

_____

_____

Previous Traumas (Including minor car accident**)** _____

Previous Treatment

Chiropractor	Primary Care	Physical Therapy	Other:_____
X-ray	CT Scan	Heat / Ice	Other:_____

Medications_____

_____

Surgeries_____

_____

When was your last Chiropractic treatment _____

What Technique Manual Activator Drop Table

Were you being treated for Wellness Yes No

How frequently

Primary Care Physician

Clinic Name_____ Provider Name_____

Phone_____ Address_____

Circle Any Recent Change in the Following Functions

Concentration	Forgetfulness	Memory Loss	Fatigue
Weight Changes	Night Sweats	Convulsion	Fainting
Rash / Redness	Hair Change	Nail Change	Itching
Absence of Smell	Nose Pain	Nose Bleeds	Anxiety
Hearing Trouble	Ear Pain	Mood Swing	
Change in Taste	Mouth Sores	Mouth Bleeding	
Difficulty Breathing	Cough	Wheezing	
Heart Murmurs	Palpitations	Depression	
Swollen Arms	Swollen Legs	Blue Arms	Blue Legs
Appetite Change	Digestive Changes	Impotence	
Inability to Urinate	Frequent Urination	Painful Urination	
Heat Intolerance	Cold Intolerance	Tremors	

Females Are you pregnant		No Yes	Not Sure
Discharge of Breast	Breast Lump	Breast Red/Itching	Breast Pain
Irregular Menstruation	Vaginal Pain	Vaginal Bleeding	

Family Illness Father _____ Mother _____ Sibling _____

Circle Any of the Following Disorders that Apply to You

Multiple Sclerosis	Scoliosis	Polio	Kidney	Heart Disease
High Blood Pressure	Cancer	Asthma	Ulcer	Hay Fever
Low Blood Pressure	HIV	Allergies	STD	Tuberculosis
Emotional Disorder	Epilepsy	Thyroid	Arthritis	Bone Fracture
Rheumatic Fever	Sinusitis	Diabetes	Prostate	Spinal Disc Disease

Name **Date** **SIGN HERE ►**

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