**COMPLETE CHIROPRACTIC & BODYWORK THERAPIES**
**CLIENT INTAKE FORM**

Date: _____ Referral Source: _____

Name_____
Last First Middle Name I prefer to be called
Address _____
City State Zip
Phone (___)_____(___)_____(___)_____
Home Work Cell/Pager
Employer_____
Address Occupation
Email _____ Social Security#_____ Male____ Female ____

Date of Birth _____ Age _____ Marital Status: S M W D Partner

Emergency Contact _____
Phone # Relationship

***Height_____Weight_____***

***Please state your chief complaint:***

_____

_____

***How long have you had the symptoms?***

_____

***How did the condition begin?***

_____

***How long did the symptoms last?***

_____

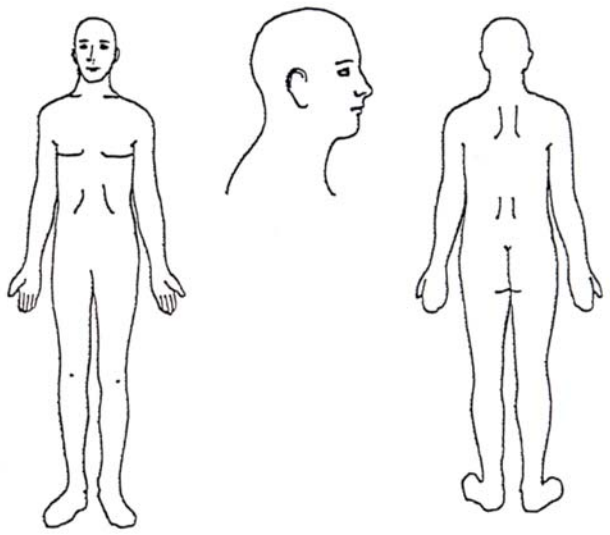
***What makes it worse?***

_____

***What makes it better?***

_____

Please mark your areas of pain on the figures below



***How would you describe your pain on a scale of 1 to 10? Circle one:***
***(1 is mild, 10 severe) 1 2 3 4 5 6 7 8 9 10***

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***Check those that apply:***

| | | | |
|---|---|---|---|
| ____***Constant*** | ____***Intermittent*** | ____***Occasional*** | ____***Sharp*** |
| ____***Dull*** | ____***Weakness*** | ____***Numb*** | ____***Radiating*** |
| ____***Spasm*** | ____***Tingling*** | | |