



20120 76th Ave West • Edmonds, WA 98026
Ph: 425.712.9277 • F: 425.775.5085
W W W . S Y M E S C H I R O . C O M

PATIENT INTAKE FORM

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
SS#: _____ 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? _____
Have you seen any other providers for this condition? _____
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, if accomplished, would have the greatest impact on your life? _____

SYMES CHIROPRACTIC

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HEALTH CONCERNS

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Digestive Troubles |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Pain in Arms/Legs |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Inability to Concentrate |
| <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Other: _____ | |

Explain any boxes checked above or add additional concerns: _____

Is there anything else regarding your current condition the Doctor should know? _____

MEDICATIONS

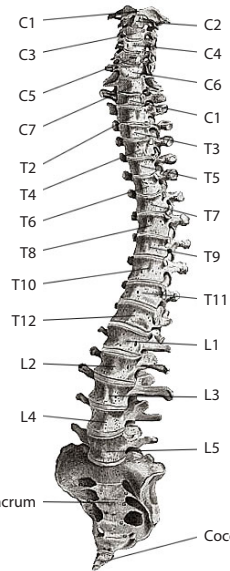
- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other: _____ | |

Explain any checked boxes above: _____

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle concerns below or enter the information to the left.

- Headaches
- Migraines
- Dizziness
- Sinus Problems
- Allergies
- Fatigue/Sleep Problems
- Head Colds
- Vision Problems
- Heart Conditions
- High Blood Pressure
- Difficulty Concentrating



- Middle Back Pain
- Congestion
- Difficulty Breathing
- Bronchitis
- Pneumonia
- Gallbladder Conditions
- Stomach Problems
- Ulcers
- Gastritis
- Kidney Problems
- Indigestion

- Constipation
- Colitis
- Diarrhea
- Gas Pain
- Irritable Bowel
- Bladder Problems
- Menstrual Problems
- Low Back Pain
- Pain/Numbness in Legs
- Reproductive Problems

VITAMINS/SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Other: _____ | |

Additional Notes: _____

HEALTH STATUS QUESTIONNAIRE

Rate based on frequency scale of 1 - 5. 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Regularly, 5 = Constantly

Your Physical Life	Nev	Rar	Occ	Reg	Con	Stress Evaluation	Nev	Rar	Occ	Reg	Con
Presence of physical pain	1	2	3	4	5	Family	1	2	3	4	5
Colds or flu	1	2	3	4	5	Significant life change	1	2	3	4	5
Chronic disease	1	2	3	4	5	Health	1	2	3	4	5
Ability to work out or engage in activity	1	2	3	4	5	Work/school	1	2	3	4	5
Tension, stiffness, lack of flexibility	1	2	3	4	5	Day-to-day stress	1	2	3	4	5
Fatigue or low energy	1	2	3	4	5	Finances	1	2	3	4	5
Mental/Emotional State	Nev	Rar	Occ	Reg	Con	Life Enjoyment	Nev	Rar	Occ	Reg	Con
Negative feelings	1	2	3	4	5	Recreational activities	1	2	3	4	5
Sleeping difficulties	1	2	3	4	5	Time devoted to hobbies	1	2	3	4	5
Depression/Anxiety	1	2	3	4	5	Experiences of well-being and relaxation	1	2	3	4	5
Moodiness, temper, angry outbursts	1	2	3	4	5	Interest in maintaining a healthy lifestyle	1	2	3	4	5
Being overly worried about small things	1	2	3	4	5						
Difficulty thinking or concentrating	1	2	3	4	5						

What else about your health do you feel is important for the doctor to know? _____

FAMILY HEALTH PROFILE

In addition to your health, we here at Symes 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.):

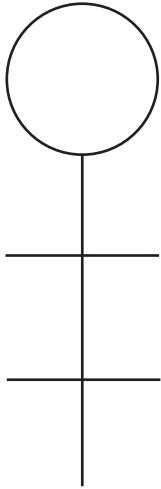
Spouse/Partner: _____
 Parents: _____
 Siblings: _____
 Close Friends: _____

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

 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: _____

