Paramount Chiropractic & Wellness
2050 N Plano Rd, Suite 200A
Richardson, Tx 75082
T: 972-685-0422

Date: _____

CONTACT INFORMATION

Name: _____ Birth Date: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Whom may we thank for referring you: _____

Primary Doctor: _____ Marital Status: **S M D W** Spouse's Name: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Occupation: _____ Employer: _____

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before:

If yes, doctor's name:

Date of last chiropractic visit: _____ Reason for care: _____

Date of last chiropractic x-rays: _____ How long were you under care _____ :

ACCIDENT INFORMATION

Is this condition due to an accident:

Type of accident: □ Auto □ Work □ Home □ Other _____

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Patient Intake Form

Check box to indicate if you have had any of the following:

- Headaches/Migraines
- Dizziness or light-headed
- Jaw pain/clicking/ locking
- Neck pain or stiffness
- Shoulder pain
- Mid back pain
- Chest pain or cough
- Arm/hand numbness/ tingling
- Arm/hand fatigue/ weakness
- Low back pain/Sciatica
- Leg/foot numbness/ tingling
- Leg/foot fatigue/ weakness
- Leg pain with walking
- Sensitive to light
- Sensitive to sound
- Visual problems
- Hearing problems
- Memory loss/problems
- Irritability or depression
- Fatigue or loss of energy
- Trouble with balance or coordination
- Sleep problems
- Rashes (face, body, limbs)
- Joint pain or swelling
- Pain with exertion i.e. activity, climbing stairs
- Chronic Sinus
- Ear Infections
- Allergies
- Asthma
- Difficulty Breathing
- Kidney problems
- Digestion problems
- Poor circulation
- Bladder problems
- Prostate problems
- Thyroid problems
- Alcohol/Drug Abuse
- AIDS/HIV
- Epilepsy/ Fainting/Seizures
- Osteoporosis
- Osteo Arthritis/ Rheumatoid Arthritis
- Heart Attack/Stroke
- Heart Defect/Condition
- Heart Surgery/Pacemaker
- High Cholesterol
- Low/High blood pressure
- Diabetes Type 1/Type II
- Shingles
- Cancer/Chemotherapy
- Venereal disease
- Hepatitis
- Ulcers/Colitis/IBS
- Artificial Bones/Joints
- Abnormal menstrual cycle

Do you smoke: How much: _____ How long: _____

Are you wearing: □ Heel lifts □ Arch Supports □ Other Supports

List ***all medications/supplements/controlled substances*** you are taking. List ***any medication*** allergies:

_____

List all ***surgical operations*** and years:

_____

List all ***serious accidents*** with dates: (motor vehicle accidents, falls, spills or broken bones):

_____

_____

_____

Are you pregnant: □Yes □ No

Expected Delivery Date: _____

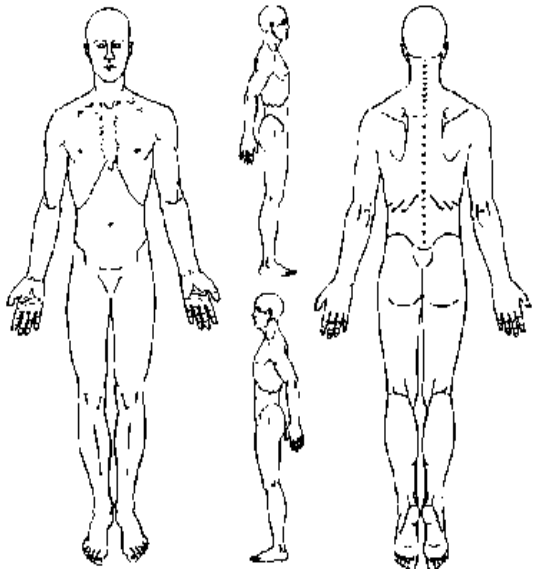
CURRENT CHIEF COMPLAINT/CONDITION

What is your pain level today? (least 1 -10 worst)_____

What is your major complaint? _____

How long have you had this condition? _____

What is this preventing you from doing? _____



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Patient Intake Form

Have you had this or similar conditions in the past:

What activities aggravate your condition: _____

Is this condition getting progressively worse:

☐ Constant ☐ Comes and goes

Is this condition interfering with your

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: _____

Other Providers who (HELPED OR NOT) that treated this condition:

_____

Do you exercise regularly? N/Y If Yes, what is your main routine?

_____

What is your diet/food intake like? (vegan, vegetarian, keto, carnivore, high carb, fasting):

_____

What are your GOALS by incorporating Chiropractic with us?

_____

*Please let us know about anything else you think may be impacting your health or related to your pain/injury. Your Doctor (D.C.) will consult with you thoroughly/in detail about it.

_____
_____
_____
_____
_____

I _____ Give Paramount Chiropractic & Wellness and any of its subsidiaries to consult and examine me upon signing this document.

Signature of Patient: _____ Date: _____