Health History Intake Form

First Name_____M.I_____Last Name_____Phone(_____)_____

Address_____City_____State_____Zip_____

Sex_____Age_____Birthdate_____/_____/_____ Marital Status (M S W D) Children_____

Insured's Name:_____Birthdate _____/_____/_____ Social Security#_____

Health/History Information: Have you had previous Chiropractic Care? ☐ Yes ☐ No

If so, when and for what condition? _____

How was your experience? _____

Have you had previous CFR/NCR/BNS/Cranial Balloon Therapy Before? ☐ Yes ☐ No

If so, when, by whom, and for what condition? _____

How was your experience? _____

Dental History: Braces? Root canals? Extractions? Current dental issues? Dental surgeries? _____

_____

Are you allergic to latex? ☐ Yes ☐ No **Are you absolutely positive?** ☐ Yes ☐ No

Patient Questionnaire:

What is your primary complaint and rate of severity? (1 to 10 with 10 being the worst)_____

_____

_____

How long have you had these symptoms? Approximate onset? _____

_____

Do you have any other complaints?_____

_____

Have you ever had any head, facial, jaw trauma, or surgery? _____

_____

Do you ever have difficulty breathing out of your nose? _____

_____

Other Conditions (Please check all that apply):

☐ Headache
☐ Neck pain
☐ Neck stiff
☐ Back pain
☐ Jaw pain
☐ Jaw clicking
☐ Teeth grinding
☐ Teeth clenching
☐ Dental surgery
☐ Braces
☐ Anxiety
☐ Dizziness
☐ Lightheadedness
☐ Sinusitis
☐ Snoring
☐ Sleep Apnea
☐ Difficulty Breathing
☐ Sensitivity to Light
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Pins & Needles in arm/hands
☐ Pins & Needles in legs/feet
☐ Tingling or numbness in face
☐ Fatigue
☐ Depression
☐ Memory Loss
☐ Fainting
☐ Facial Pain
☐ Ringing in Ears
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Chest pain
☐ Feet cold
☐ Hands cold
☐ Seizures
☐ Concussions
☐ Substance Abuse
☐ Addictions

Do you have family members with similar symptoms?_____

What have you done for treatment of these symptoms? Start from the beginning and include the number of doctors seen and type of drugs taken. Any surgeries?_____

Have your symptoms changed since the onset – have they gotten better or worse? Explain:_____

To what extent have these health problems interfered with your normal life?_____

How did you hear about Cranial Facial Release Technique (CFR)?_____

How are you hoping CFR will help you? What are your treatment goals?_____