CORE CHIROPRACTIC - INTAKE & HISTORY

Patient Name		INFOR	MATION								
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Spouse's Employer Spouse's Occupation Spouse's	Address			MIDDLE	INITIAL	Spouse'	s Name				
Spouse's Occupation				State							
Case Phone	-					•					
Name											
Relationship Contact Number Widowed Single Minor Contact Number Contact Number Divorced Partnered Who may we thank for referring you? HOW CAN WE HELP YOU? What brings you in today? If you are already experiencing a symptom, what is it? How bad is it? How intense are your symptoms? (circle) No SYMPTOMS Please circle areas to the right where you have pain or other symptoms: What does it feel like? (check where appropriate) Symptoms Symp								-			
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B. In what direction is yo	ur health curre	ently headed?							
/hat are your health goals	?								
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SHORT TERM .									
LONG TERM _									
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