

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):

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