

MOVE BETTER. PLAY BETTER. LIVE ELITE.

Please complete before your visit. Check all that apply; use N/A when needed.

1. PATIENT INFORMATION

Full name

Date of birth

Age

Height (ft/in or cm)

Weight (lb or kg)

Date

Occupation

Hours seated per day

Mobile phone

Email

Address / city / state / ZIP

Emergency contact / relationship

Phone

Primary care provider

Phone

2. REASON FOR VISIT & CURRENT SYMPTOMS

☐ Pain / discomfort

☐ Tightness / stiffness

☐ Weakness

☐ Balance / coordination

☐ Fatigue / recovery

☐ Performance concerns

Main concern / body area / right or left side

When did it start?

Current pain: circle 0 (none) through 10 (worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

☐ Constant

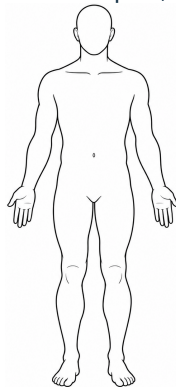
☐ Comes and goes

☐ Only with activity

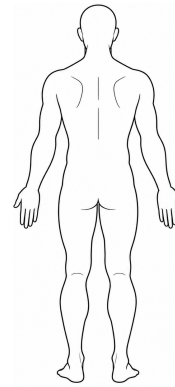
What makes it worse?

What helps?

Mark the problem areas below: P = pain, T = tightness, N = numbness.



Front



Back

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3. YOUR GOALS

- | | | |
|---|---|--|
| ☐ Move without pain | ☐ Mobility / flexibility | ☐ Strength / speed |
| ☐ Coordination / balance | ☐ Recovery / injury prevention | ☐ Nutrition / hydration |

Most important goal / activity you want to return to

Describe the marked areas: location / symptoms / when they occur

How do these concerns affect daily activities or exercise?

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4. SPORTS & ACTIVITY PROFILE

Sport(s) / activities

Recreation / league / events

Active days per week

Exercise hours per week

Recent change in activity

☐ Right hand dominant

☐ Left hand dominant

☐ Uses both hands

Other training / strength work / activity

5. INJURIES, TREATMENT & HEALTH HISTORY

☐ Neck

☐ Shoulder

☐ Elbow

☐ Wrist / hand

☐ Mid-back / ribs

☐ Low back

☐ Hip

☐ Knee

☐ Ankle / foot

Injury / date / treatment / any ongoing limits (include fractures or dislocations)

	Yes	No	Unsure
History of concussion or significant head injury?	☐	☐	☐
Has a provider restricted sports or activity?	☐	☐	☐
Previous chiropractic care or physical therapy?	☐	☐	☐

If yes: details, dates, and any current restrictions

☐ Asthma / breathing issues

☐ Heart condition

☐ Seizures

☐ Diabetes

☐ Bleeding disorder

☐ Arthritis / osteoporosis

☐ High blood pressure

☐ Other diagnosed condition

☐ None known

Diagnoses, surgeries, hospital stays, or other important history (include dates)

Allergies (medication, food, latex, environmental) / reaction

Relevant family medical history (including heart conditions / sudden death)

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6. WORK, EXERCISE & RECOVERY

- | | | |
|--|---|---|
| ☐ Running / walking | ☐ Golf / tennis / pickleball | ☐ Cycling / swimming |
| ☐ Weight training | ☐ Recreational team sports | ☐ Other activities |

Typical weekday activity vs. weekend activity

	Yes	No	Unsure
Returning to exercise after a break or injury?	☐	☐	☐
Pain or stiffness the day after exercise?	☐	☐	☐
Work involves lifting, repetitive tasks, or prolonged sitting?	☐	☐	☐
Have you reduced activity because of pain or fear of injury?	☐	☐	☐

Details / recovery time / activity demands

7. SYMPTOMS YOU HAVE NOTICED

Check symptoms that are current or recurring. These guide the discussion at the visit.

- | | | |
|--|--|--|
| ☐ Headaches | ☐ Dizziness | ☐ Neck discomfort |
| ☐ Shoulder / arm discomfort | ☐ Back discomfort | ☐ Hip / knee / ankle pain |
| ☐ Numbness / tingling | ☐ Muscle cramps | ☐ Weakness |
| ☐ Poor balance | ☐ Jaw discomfort | ☐ Vision / hearing concerns |
| ☐ Difficulty sleeping | ☐ Fatigue / low energy | ☐ Stress / worry |
| ☐ Mood / behavior changes | ☐ Trouble concentrating | ☐ Skin issues / rashes |
| ☐ Reflux / heartburn | ☐ Bloating / gas | ☐ Constipation |
| ☐ Loose stools / diarrhea | ☐ Abdominal pain | ☐ Frequent illness |

Other symptoms / when they started / how often they occur

8. ACTIVITY-RELATED CONCERNS

	Yes	No	Unsure
Chest pain, fainting, or unexplained breathlessness during exercise?	☐	☐	☐
Trouble tolerating heat or a previous heat-related illness?	☐	☐	☐
Symptoms limit exercise, work, or usual activities?	☐	☐	☐

Details / medical evaluation / missed work or exercise

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9. NUTRITION, HYDRATION & RECOVERY

Typical meals / snacks / dietary restrictions

Water per day (oz or cups)

Sports drinks / caffeine / energy drinks

☐ Mostly whole foods

☐ Mix of whole / packaged foods

☐ Mostly packaged / fast food

Food intolerances / digestive concerns

Sleep hours per night

Usual bedtime

Usual wake time

☐ Wakes rested

☐ Trouble falling asleep

☐ Wakes during night

☐ Snoring

☐ Daytime tiredness

☐ Unsure

Alcohol per week / tobacco or vaping

Stretching / mobility / recovery routine

10. MEDICATIONS, SUPPLEMENTS & EXPOSURES

Medications: name / reason / dose / how often (or write none)

Supplements: name / dose / how often (or write none)

	Yes	No	Unsure
Antibiotics taken during the past 12 months?	☐	☐	☐
Exposure to smoke / vaping, mold, pesticides, or other chemicals?	☐	☐	☐

If yes: details / number of antibiotic courses

11. ANYTHING ELSE & PATIENT CONFIRMATION

What else would you like Dr. Troy to know?

To the best of my knowledge, these answers accurately describe my health history.

Please discuss questions with the clinician. This intake is separate from treatment consent.

Patient signature (sign by hand)

Date