Adult Intake

Confidential Patient Information:

Name: ___________________________ Preferred Name: _______________________ Date: _______________

SS#: ______________________________ DOB: ______________________ Age: _________ Sex: ☐ M ☐ F

Street Address: ____ Height: _______________

City, State, Zip: ____ Weight: _______________

Cell Phone: _______________________________________ May we leave you a message: ☐ Yes ☐ No

Other Phone: _____________________________________ May we leave you a message: ☐ Yes ☐ No

Email: ____

Would you like to receive emails (special offers, upcoming events, newsletters) ☐ Yes ☐ No

Emergency Contact: _______________________ Emergency Relationship: _______________________

Emergency Phone: ____________________________

Marital Status: _______________________ Spouse Name: ____

# of Children: ___________ Names and birthdates: ____

Occupation: _________________________ Employer: ____

How did you hear about us? ____

Who is your primary care physician? ____

Date and Reason for your last doctor visit: ____

Are you also receiving care from any other health care professionals? ☐ Yes ☐ No

Please note any significant family medical history: ____

____

Current Health Conditions:

What health concern(s) bring you into our office? ____

Have you received care for this problem before? ☐ Yes ☐ No

If yes, please explain: ____

When did the symptom(s) first begin? ____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post– Injury

Is this condition: ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the symptom(s) better? ____

What makes the symptom(s) worse? ____

What is this affecting, that is **MOST** important in **YOUR** life? ____

____

Your Top Three Health Goals:

1. ____
2. ____
3. ____

Chiropractic History:

What would you like to gain from chiropractic care? ☐ Resolve existing conditions ☐ Overall wellness ☐ BOTH

Have you ever visited a chiropractor? ☐ Yes ☐ No

If yes, what is their name or clinic name? ____

Do you know that Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

Do you know what **subluxations** are? ☐ Yes ☐ No

Do you have any health concerns for other family members today? ☐ Yes ☐ No

If yes, please explain: ____

Traumas:

Have you ever had any significant falls or other injuries as an adult ? ☐ Yes ☐ No

- If yes, please explain: ____

Please list all surgeries, including year: ____

Notable childhood injuries? ☐ Yes ☐ No - If yes, please explain: ______________________

Youth or College sports? ☐ Yes ☐ No - If yes, please explain: ______________________

Any Auto accidents? ☐ Yes ☐ No - If yes, please explain: ______________________

Exercise Frequency : ☐ None ☐ 1-2x per week ☐ 3-6x per week ☐ Daily

Type of exercise: ____

How do you sleep? ☐ Back ☐ Side ☐ Stomach - Do you wakeup: ☐ Refreshed and Ready ☐ Stiff and Tired

- Average hours of sleep you get per night? ______

Do you commute to work? ☐ Yes ☐ No How many hours: ______

How many hours per day do you typically spend sitting at a desk or on a computer, tablet or phone? _________

Toxins: Chemical and Environmental Exposure

Please rate your consumption for each:

	None		Moderate		High		None		Moderate		High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar & Sweets	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs you are taking and why: ____

____

Thoughts: Emotional Stresses and Challenges

Please rate your STRESS for each

	None		Moderate		High		None		Moderate		High
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Patient Name: ______________________________ Date: ______________________________