Chiropractic for Your Family

White Rose Family Chiropractic, LLC

NPM INTAKE FORM

Name:	Date of Birth	Date:
Address:		City/State/Zip:
Home Phone No.:	Work Phone No:	Cell Phone:
Email Address::	Gender:	Ethnicity, Race, Primary Language
Occupation:	Employee Name and Address:	
Best Time and Method to Contact:	Marital Status:	
Number of Children :	Names and Ages:	
Last 4 digits of SSN:	Are you Pregnant? If yes, how many weeks?	
Referred By:	Have you been to a Chiropractor before? __ Yes __ No If yes, when was your last adjustment?	

PERSONAL INFORMATION:

As a society we are 50th in the world in health care. We take pride in helping people attain their optimum health and wellness. With that being said, we need an honest assessment of your current level of health. So please place an "X" on the scale below, indicating your level of health and wellness at this time. Then place a star (*) on the diagram, showing us the desired location of your health and wellness.

Very challenged	Challenged	Transition	Good	Excellent
0-50	50-75	75-100	100-125	125+

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or concerns right now and you are here for Chiropractic Wellness Services please skip to the "General History" page.

Health Concerns:	Severity 1 = mid 10 = worst imaginable	When did this start?	Are symptoms constant or intermittent?	Did the problem begin with an injury?

Since the challenge started, it is: _____The Same _____Getting Better _____Getting Worse

What makes it worse? _____

What, if anything makes it feel better? _____

This interferes with your: ____Work ____Leisure ____Sleep ____Sports ____Other: ____

It's common for people to have multiple doctors on their health care team. Which doctors have you seen for your challenges? ___Chiropractor ___ Medical ___Other
(Please List):
_____

During the above visits was the cause of your health challenge identified? ___Yes ___No

If yes, what was the diagnosis? _____

What was the recommended solution? _____

GENERAL HISTORY:

Given that prescription medications are in the top 5 leading causes of preventable death in the United States, we are interested in knowing what, if any, medications you take and why:
_____
_____

It is becoming more popular for people to take charge of their own health and wellbeing. Supplementation is a major trend in this movement. Please list any supplements or vitamins that you are taking and why:
_____
_____
_____

Have you had any surgeries or hospitalizations? (Please include all surgeries)
_____
_____
_____

Have you ever had any work related injuries?
_____
_____
_____

Slips and falls, although common have a direct impact on your health and wellbeing. Even MINOR falls or accidents cause stress, strain and damage to the spine that take up to 18 months to heal. If you have had any slips, falls or auto accidents (even minor) please list them here:
_____
_____

Since the Nervous System controls everything in your body, it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. Please check (✓) the following symptoms/challenges you have had, whether CURRENT (C) or PAST (P):

	Past	Current		Past	Current
Heachaches/migraines	☐	☐	Neck stiff/pain	☐	☐
Loss of smell	☐	☐	Loss of balance	☐	☐
Loss of taste	☐	☐	Tension	☐	☐
Ulcers	☐	☐	Dizziness	☐	☐
Fatigue	☐	☐	Irritability	☐	☐
Cold Hands	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Hot flashes	☐	☐
Intestinal issues	☐	☐	Urinary issues	☐	☐
Cold Sweats	☐	☐	Asthma	☐	☐
Fainting	☐	☐	Arm tingling	☐	☐
Back pain	☐	☐	Buzz/ring in ears	☐	☐
Nervousness	☐	☐	Numbness in fingers	☐	☐
Stomach upset	☐	☐	Numbness in toes	☐	☐
Depression	☐	☐	Sleeping problems	☐	☐
Cold feet	☐	☐	Lights bother eyes	☐	☐
Fever	☐	☐	Menstrual irregularity	☐	☐
Menstrual Pain	☐	☐	Tingling in legs	☐	☐
Heartburn	☐	☐	Heart Attack	☐	☐
Cancer	☐	☐	Allergies	☐	☐
High Blood Pressure	☐	☐	High Cholesterol	☐	☐
Tobacco Usage	☐	☐	Drink Alcohol	☐	☐

If we have not listed current health challenges on the list above please now list additional health concerns in the lines below:

_____
_____
_____
_____

THANKS FOR PROVIDING US WITH PIVOTAL INFORMATION THAT CAN LITERALLY CHANGE YOUR LIFE!
ON TO THE NEXT PAGE!!!

It has been shown that daily lifestyle stress significantly impacts overall health and wellbeing. As a family wellness office, we specialize in removing the cause of your health challenges. We also focus on teaching you how to manage the lifestyle stresses that prevent you from realizing your optimum health and wellness.

Please rate the following and circle ALL answers that apply to your habits:
(1 being very poor and 10 being excellent)

Eating habits: _____
a. I eat 3-5x's a day
b. I eat fruits and vegetables daily.
c. I eat out 2-3 times weekly (min)
d. I drink 3-5 sodas weekly
e. I crave sweets.
f. I don't watch what I eat.

Exercise habits: _____
a. I exercise 3-5 times a week.
b. I walk daily.
c. I don't exercise.
d. I want to exercise.
e. I sit at computer 6-8 hours/day

Sleep: _____
a. I sleep 7-9 hours/night
b. I wake up well rested
c. I wake up tired.
d. I toss and turn.
e. I stay up late.

Mind Set: _____
a. I have a positive outlook.
b. I have a negative outlook.
c. I am always in a bad mood.
d. I am always in a good mood.
e. I trap things inside.
f. I share easily.

General Health: ____
a. I am not on medications.
b. I take care of myself.
c. I watch what I eat.
d. I base my health on how everyone around me is doing.
e. I think I am healthy but know I could make some changes.

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
Occupational: _____
Personal: _____

YOU ARE ALMOST THERE!

THANKS FOR PROVIDING US WITH INFORMATION THAT COULD HELP US TO BETTER SERVE YOU AND HELP YOU TO BE THE BEST YOU CAN BE!

YOUR GOALS

At our office, we pride ourselves in helping you to achieve phenomenal results with your health and wellness. So that we can help you achieve your optimum health it is important that we understand your goals for your overall health and wellbeing.
Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/Biochemical Goals	Psychological Goals

If there is a need for dietary changes would you like to know? ☐ Yes ☐ No

If there is a need for specific exercises would you like to know? ☐ Yes ☐ No

If there is a need for support in the psychological, mind-body or stress management dimensions of health would you like assistance? ☐ Yes ☐ No

YOU ARE ALMOST THERE! DO YOU:

Drink water? ☐ Yes ☐ No How much? _____
Belong to a health club? ☐ Yes ☐ No
Consume vitamins or supplements? ☐ Yes ☐ No
Eat organic foods? ☐ Yes ☐ No
Have a weight management program? ☐ Yes ☐ No
Get more than 6 massages in a year? ☐ Yes ☐ No

Now we just need your permission to continue through our process!

I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____

THANK YOU FOR FILLING OUT THIS FORM.
IT IS YOUR FIRST STEP TO CREATING WELLNESS!
Present this to our staff and in a moment we will be starting our journey together!

White Rose Family Chiropractic
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